



# Infant & Toddler Connection of Virginia

## Practice Manual

June 2010

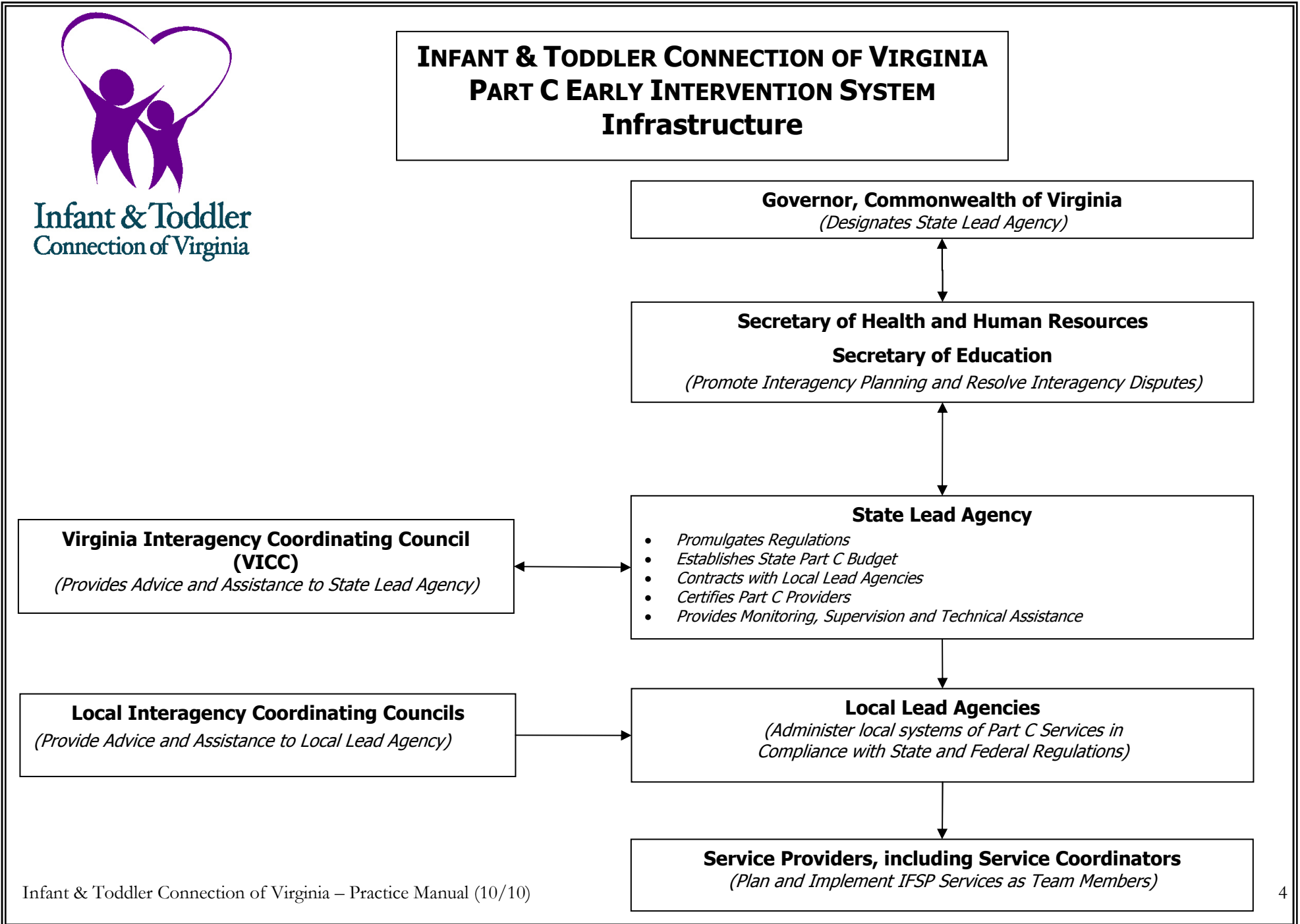
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## Chapter 1: Principles of Part C Early Intervention

1. Early intervention supports and services are available to all eligible infants and toddlers and their families through the Infant & Toddler Connection of Virginia regardless of the family's ability to pay.
2. The purpose and focus of Part C supports and services are to increase the child's participation in family and community activities identified by the family and to support the family in identifying learning opportunities and enhancing their child's development.
3. Consideration of family routines, activities and natural settings occurs throughout the early intervention process from child find, assessment, and delivery of entitled services on through transition from services.
4. Supports and services occur in the context of and are integrated into the normal daily activities, routines and environments of each child and family. Supports and services fit into the family's life and build effectively on the resources and supports already in place.
5. Parents already do things to teach their children everyday – they are the primary agent of change in their child's development and the experts on their child and family. Part C providers add their specialized skills and knowledge and work as a team with the parents and other caregivers to identify and use existing learning opportunities and create new ones as needed to address the outcomes that the family and Part C providers have developed together.
6. Individualized outcomes are relevant for the family, focus on the child's participation in activity settings that are important to the family, and focus on the whole child rather than specific developmental skills.
7. Service delivery options, including specific supports and services, service providers, and locations of service delivery are determined *after* the desired outcomes and potential learning opportunities have been identified. Providers partner with families to make an individualized determination about the supports and services that are necessary to support the child's ability to participate in family and community activities.
8. Service providers use multiple methods, including accommodations, adaptations, coaching with parents/caregivers, and expanding activity settings, to accomplish outcomes.
9. Effective Part C early intervention requires an active parent-provider partnership that includes involvement by the family/caregiver in each early intervention session. The focus is on expanding the parents'/caregivers' confidence and competence to help the child learn during everyday activities.
10. The State Lead Agency for the Infant & Toddler Connection of Virginia monitors local system status on statewide performance and compliance standards to promote timely and effective Part C early intervention services for all eligible infants, toddlers and families.



## Chapter 3: Referral

An effective referral process ensures early identification of eligible children, timely supports and services for eligible children and families, and a strong base of referral sources who understand what is available through the Infant & Toddler Connection system and can rely on early intervention providers to partner with them in supporting the child and family they have referred. Referral is the first point of contact between the Infant & Toddler Connection system and the family. It is also a critical point of contact between the Infant & Toddler Connection system and the primary referral source. All referrals must receive a timely, professional and family-centered response.

### Public Awareness and Child Find

#### Local Lead Agency Responsibilities:

1. Use statewide materials and ensure that any local public awareness materials that are developed to use in addition to the statewide materials are consistent with the statewide public awareness materials and reflect the diversity of the local community.
2. Coordinate local activities with planned statewide public awareness activities (e.g., airing of public service announcements, dissemination of materials).
3. Provide notice throughout the community before any major child find activity takes place.
4. Disseminate materials to local agencies and places of business. The following agencies/businesses may be targeted for dissemination of information:
  - a. Pediatricians'/general practitioners' offices;
  - b. Hospitals, including NICUs and NICU follow-up and other outpatient clinics;
  - c. WIC clinics;
  - d. Well-baby/immunizations clinics and mobile vans;
  - e. Community and migrant health centers;
  - f. Head Start and Early Head Start programs;
  - g. Family support programs;
  - h. Child day care centers and family day care homes;
  - i. Visiting public health nurse programs;
  - j. Local social service departments;
  - k. Programs that serve families affected by substance abuse;
  - l. Mental health clinics;
  - m. Civic groups;
  - n. Ethnic/community centers;
  - o. Homeless family shelters;
  - p. Family planning organizations;
  - q. Businesses (e.g., banks, utility companies, grocery stores, laundromats, beauty parlors, etc.);
  - r. Places of worship;
  - s. Professional associations;
  - t. Advocacy associations;
  - u. Private providers;
  - v. Public schools;
  - w. Adoption agencies;
  - x. Parent support groups; and
  - y. Other local points of contact with families and young children.

5. Develop and implement local public awareness and child find procedures that include the following:
  - a. The methods to be used for planning and distributing public awareness information;
  - b. The roles of agencies and individuals in the community involved in public awareness activities, including, but not limited to:
    - Public agencies (e.g., local school systems, Head Start and Early Head Start, health agencies, social service departments);
    - Private entities (e.g., pediatricians);
    - Lay groups (e.g., Chambers of Commerce, service organizations, neighborhood associations, faith based organizations, major employers, advocacy groups); and
    - Agencies and individuals who represent underserved groups, including minority, low-income, homeless and rural families and children, and children with disabilities who are wards of the State.
6. Involve primary referral sources, especially hospitals and physicians, in the child find system.
7. Inform primary referral sources, especially hospitals and physicians, about procedures to assist families in accessing the local Infant & Toddler Connection system. Emphasize that, although, under Part C, parent consent is not needed in order to make a referral to the local Infant & Toddler Connection system it is strongly recommended that the referral source inform the family prior to making the referral, explaining the reasons for the referral and the benefits of early intervention.
8. Work with physicians and other local agencies/providers to use a variety of mechanisms that may include, but are not limited to, mass general screenings, well baby checks, individual child screens, medical records/chart review, documentation of needs by primary referral sources, and parent observation and report to identify infants and toddlers potentially eligible for Part C early intervention services. Emphasize their responsibility to refer potentially eligible children to the local Infant & Toddler Connection system.
9. Determine the required single point of entry for the local Infant & Toddler Connection system.
10. Collect and enter data into ITOTS for every child referred to the local Infant & Toddler Connection system in accordance with the most current terms of the *Contract for Participation in Part C Early Intervention for Infants and Toddlers with Disabilities and Their Families*.
11. Use available data, including ITOTS data, regarding which children are receiving supports and services to evaluate the effectiveness of local public awareness and child find efforts on an ongoing basis and to determine the need to revise interagency agreements and other efforts related to child find and public awareness.

#### Provider Responsibilities

1. Refer to the single point of entry any child potentially eligible for Part C who becomes known to the provider through a source other than the Part C system and who is potentially eligible for Part C.

## Receiving and Processing a Referral

### General:

1. Each local Infant & Toddler Connection system must designate a single point of entry for receiving all referrals to the local system.
2. Referrals may be made by phone, fax, in writing or in person to the local single point of entry.
3. It is not necessary to have parent consent in order to make a referral to the local Infant & Toddler Connection system, and the local system must still accept a referral even if the referral source has not informed the family.
4. The referral source must provide at least the child's or family member's name and one method of contact in order for the communication to be considered a referral.
5. The date of referral to the local Infant & Toddler Connection system is day one of the 45-day timeline for development of the initial IFSP.
  - a. If a referral is received when the office is closed (e.g., for the weekend or on a State or federal holiday), then the referral is processed on the next business day. That next business day, when the staff member hears the message on the answering machine or reads the fax, email or written referral received through the mail, is considered the date of the referral. The local system must ensure timely processing of referrals through sufficient staffing of the single point of entry with back-up available when an individual is ill or on vacation. If the single point of entry office is closed for an extended period, such as during a week-long spring break or winter holiday break, then there must be a mechanism for processing referrals during that period.
  - b. If a family or referral source calls the single point of entry just to ask a question about child development or to get other general information, then this is not considered a referral.
  - c. The date of referral for a child referred from another local early intervention system (from either in or out of state) is the date the child is available (i.e., has moved into the area served by the local system) or the date of referral, whichever comes last.
  - d. If a child was previously enrolled in the Infant & Toddler Connection system but has been out of services for 6 months or more when he/she is again referred to the local system, then the local system must conduct a new eligibility determination and assessment for service planning, establish new entry ratings on the child indicators (if the child is still 30 months old or younger), and establish a new IFSP within 45 days of the new referral and before resuming services.
6. Children referred from another local early intervention system in Virginia and those who have been previously enrolled in the current or another local early intervention system in Virginia and who have been out of early intervention services for less than 6 months may not require all of the steps (e.g., eligibility determination, assessment for service planning, IFSP development) that other new referrals require.
  - a. The steps necessary for a child that is transferring from another local system will depend on where that child was in the early intervention process with the sending local system. For instance, if eligibility determination had been completed by the sending local system, then the receiving local system can pick up with assessment for service planning. If a child with a current IFSP moves within Virginia, communication and



coordination should occur between the sending local system and the receiving local system in advance of the move, whenever possible, to enable supports and services to be in place in the receiving local system based on the current IFSP. The family's new service coordinator will schedule an IFSP review soon after the family moves in order for the new IFSP team to review the existing IFSP and make any necessary modifications.

- b. If a child has been out of services in Virginia for less than 6 months, then it is only necessary to conduct a new eligibility determination if there is an indication that a significant change has occurred in the child's developmental status since the child left the system. Similarly, if an IFSP had already been developed for this child and family, then the local system may resume services in accordance with that IFSP as long as it was signed by the family and as long as the family does not indicate significant changes that would suggest the need for an IFSP review. Once services resume, an IFSP review may be held if either the providers or family identify a need to discuss changes in outcomes or services.
7. Information received by the local Infant & Toddler Connection system in a referral is considered confidential under the Family Educational Rights and Privacy Act (FERPA).
  - a. If the local Infant & Toddler Connection system is unable to contact the family (e.g., depending on the contact information provided by the referral source, this may mean attempting to contact the family by phone, by letter and/or by stopping by the address), the single point of entry should contact the referral source to inform them that the family has not been contacted and to request additional contact information.
  - b. Once the family has been contacted, information about the referral (beyond acknowledging receipt of the referral) may not be given to the referral source without a signed consent for release of information. If the referral source wants to know the outcome of its referral, the referral source should seek consent from the family and provide a copy of a signed consent for release of information to the single point of entry at the time of referral. Information about referrals may also be given to the referral source if the parent provides consent using a local Infant & Toddler Connection system release form or the referral source later obtains parent consent and provides a copy of that signed release form to the local lead agency.
8. If the single point of entry is unable to contact a family after requesting additional contact information from the referral source or the family repeatedly fails to respond, then the dates of attempted contact must be documented in the child's record. Attempts to contact the family may be made by phone, mail, visiting the address provided by the referral source, and/or other means based on the contact information available. It is recommended that no more than 15 – 20 calendar days pass during this process of attempting to contact the family. Prior to closing the referral, a letter should be mailed to the family stating that the child's referral record will be closed if contact is not made within a given number of calendar days from the date on the letter. The letter mailed to the family must include information about how the family can re-establish contact with the local Infant & Toddler Connection system if they wish to and must include a copy of the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*. If the single point of

entry is never able to contact the family, the single point of entry should inform the referral source that the family could not be contacted and document in ITOTS that the child was not evaluated to determine eligibility because they were unable to contact the family.

#### Single Point of Entry Responsibilities:

1. Provide general information to families and/or other interested persons who have questions regarding child development and accessing Part C supports and services and/or other available resources.
2. Verify that the child is age eligible for Part C and lives in the area served by the local Infant & Toddler Connection system.
  - a. If it is clear at the time of referral that the child is past his third birthday or lives outside the area served by the local system, then inform the referral source and provide information about where and how to make an appropriate referral.
  - b. If it is determined after contact with the family that the child is three or older or lives outside the area served by the local system, then facilitate a referral to the appropriate program or services, with parent consent.
3. Collect the following information from the referral source, if available:
  - a. Child's full name
  - b. Parent(s)' name(s)
  - c. Address
  - d. Phone number(s)
  - e. Date of birth
  - f. City/County of Residence
  - g. Gender
  - h. Reason(s) for referral
  - i. Whether developmental screening and/or assessment have occurred
  - j. Name and contact number(s) for referral sourceIf screening and/or assessment information is available, request a copy.
4. Inform referred families whose children are close to the age of eligibility for early childhood special education services through the local school division (under Part B) that they have the option to be referred to Part B instead of or simultaneously with referral to Part C. When the child's age at referral to the Infant & Toddler Connection of Virginia means the child will no longer be age eligible for Part C services by the time the Part C process can be completed (e.g., eligibility determination, assessment for service planning, IFSP development and beginning services), then the child may be referred directly to the local school division for early childhood special education services under Part B.
5. Begin the child's Part C early intervention record (see Chapter 9).
6. Acknowledge receipt of referral by sending the *Acknowledgement Letter to Referral Source* to the referral source. This is an optional step in the process but is strongly encouraged since it conveys a professional response that promotes further referrals from this referral source. This correspondence is only for the purpose of acknowledging receipt of the referral and is intended for use with professional referral sources (e.g., physicians, social workers, school system, etc.) rather than families or neighbors.
7. Assign a service coordinator.
8. Determine, in conjunction with the service coordinator, the need for a surrogate parent to protect the rights of a child when:

- a. No parent\* can be identified;
- b. The parent cannot be located after reasonable efforts; or
- c. The child is a ward of Virginia.

The *Surrogate Parent Identification of Need* form is an optional form that may be used in determining and/or documenting the need for a surrogate parent. If a surrogate parent is needed, then:

- a. Appoint a surrogate parent in accordance with local procedures, ensuring that the surrogate parent:
  - Is not an employee of the local lead agency or any other public agency or provider that provides early intervention services or other services to the child or any family member of the child (A person is not an employee of an agency solely because he or she is paid by the agency to serve as a surrogate parent);
  - Has no personal or professional interest that conflicts with the interest of the child he or she represents;
  - Has knowledge and skills that ensure adequate representation of the child; and
- b. Notify (1) the surrogate parent-appointee using the *Surrogate Parent Appointment Letter*; and (2) the person charged with responsibility for the child or the public agency and/or other participating agency/provider charged with responsibility for the child when the child is a ward of Virginia.

The *Surrogate Parent Identification of Need* form also may be used in determining and/or documenting when a surrogate parent is no longer needed. When the surrogate parent's role ends, he/she is notified using the *Surrogate Parent Termination Letter*.

**\* Please see the section entitled "Identifying the Parent" at the end of this chapter for further information on identifying who has the rights of a parent when the child is in foster care.**

9. Ensure phone contact with the family to share basic information about the Infant & Toddler Connection system and to schedule an intake appointment with the service coordinator. This contact may be made by the single point of entry or by the service coordinator or there may be phone contact by both. The amount of information covered will depend on the family, including how much time they have available during the initial phone call and how much information they want and can receive at one time. It is expected that the information outlined in the "Early Conversations with Families" box on the next page will be discussed with families early in their experience with the local Infant & Toddler Connection system. This information may be shared during a single phone call with the family, through more than one phone conversation, or through a combination of an initial phone call(s) and the intake visit.
10. Ensure entry of referral data into the Infant & Toddler Online Tracking System, ITOTS. (See ITOTS Data Entry section at the end of this chapter)
11. If, upon initial contact, the family declines an intake visit or any further service, provide an explanation of and then mail a *Declining Early Intervention Services* form and *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System* to the family.
  - a. Make reasonable efforts to ensure the family understands the screening and eligibility determination services that are available, that these services are provided at no cost to the family, and that these services cannot be provided without parental consent.

- b. Offer to make referrals to other appropriate resources/services based on child and family needs and preferences, with parent consent.
- c. Using the bottom half of the *Declining Early Intervention Services* form, mark the first line (that they understand that eligibility determination may be conducted and that they do not choose to have their child receive an eligibility determination). Explain to the family how they can contact the local Infant & Toddler Connection system in the future using the phone number provided at the bottom of the form if they have concerns about their child's development.
- d. If the child is close to being age eligible for early childhood special education services through the local school division (under Part B), explain how to access Part B services through the local school division.
- e. Attempt to obtain parent consent to communicate with the primary care physician and the primary referral source, if not already provided. It is also acceptable to give the family the option to notify their physician themselves.

Talking with the Family about Notifying the Physician:

Consider using the following language in seeking parent permission to notify the physician: "It's important to let your physician know that your child will not be receiving early intervention services so he/she can continue to keep an eye on your child's development. We can do that if you'll give us written consent (which we can do by mail). If not, we would ask that you let your physician know yourself."

- f. Ensure that copies and explanations of the *Declining Early Intervention Services* form and *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System* are provided in the family's native language or other mode of communication unless clearly not feasible to do so.
- g. Document in ITOTS, within 10 business days of the family declining to proceed, that eligibility determination was not completed and that the reason was the family declined eligibility determination.

### Early Conversations with Families:

This list is intended to guide conversations and should not be read to families

- Be sure to introduce yourself and let the family know your role in the local system (e.g., service coordinator or staff at the single point of entry)
- Let the family know how you got their name and their child's name.
- Find out whether they knew their child was going to be referred.
- Confirm the information you received from the referral source, e.g., child's name, date of birth, address, phone number
- Ask whether the family has heard of the early intervention program before and, if so, what they have heard. This may allow you to skip some of the basic information you would typically share with a newly-referred family or give you the opportunity to address any misperceptions.
- Use concepts from the principles in Chapter 1 as the basis for sharing basic information about early intervention – early intervention is individualized, families and providers work in partnership at each step of the process, the focus is on increasing the child's participation in family and community activities and supporting the family in helping their child develop and learn.
- Remember to spend some of the conversation listening to the family. Ask the family about their child, how he/she is doing, etc.
- Briefly explain the state definition of eligibility.
- Discuss the process of eligibility determination, explaining that information already available from the child's physician or other providers will be used to help determine eligibility, along with your observations, any developmental screening information, and information from the family. Share with the family that if existing information is not enough to determine eligibility, then additional assessment will be conducted with their consent.
- Explain what will happen during the first face-to-face visit with the family.
- Ask if the family has any medical or developmental records that they are willing to share about their child, and if so, to please have those available at the intake visit. Otherwise, explain that you will be asking at that visit for their permission to request those records.
- Inform the family that the eligibility determination and development of an Individualized Family Service Plan will occur within 45 calendar days unless the family prefers to extend that timeline.
- Introduce the rights and safeguards the family has and the need for parental consent in order to proceed with Part C early intervention activities, including screening and/or eligibility determination. If you will be mailing notice and consent forms prior to the intake visit, then fully explain the family's rights and safeguards associated with screening and eligibility determination as detailed in Chapter 4.
- Explain that some services are available at no cost to families (eligibility determination, assessment for service planning, IFSP development, service coordination). Let the family know that they may meet the cost of remaining services through use of Medicaid or private insurance and/or by monthly payment of a fee that is determined based on their family size and income. Emphasize that no family will be denied services because of an inability to pay.

### ITOTS Data Entry – Referral

The local system manager ensures that the following data is entered into ITOTS:

1. Child's full name
2. Social security number, if available
3. Date of birth
4. City/County of residence
5. Gender
6. Local case number (optional)
7. Service coordinator (optional)
8. Referral source
9. Date of referral
10. If the family cannot be contacted, then mark the Eligibility Determination Completed as No and mark the appropriate box for the reason (unable to contact). This data must be entered within 10 business days of the local system deciding to close the referral because the family cannot be contacted.
11. If the family declines to proceed, then mark Eligibility Determination Completed as No and mark the appropriate box for the reason (declined eligibility determination). This data must be entered within 10 business days of the family declining to proceed.

[Complete ITOTS instructions are available at

<http://www.infantva.org/documents/forms/INST1117eR.pdf>]

### Local Monitoring and Supervision Associated with Referral

The local system manager provides the supervision and monitoring necessary to ensure the following:

1. Procedural safeguards forms are used and explained appropriately.
2. Consistent and accurate information is provided to the family and referral source at the point of referral.
3. Consistent and accurate information is provided to the family during the phone call(s) to share basic information about the Infant & Toddler Connection system.
4. Service coordinators are assigned in a timely manner to allow intake, eligibility determination, assessment for service planning and IFSP development to occur within the 45-day timeline.
5. ITOTS data entry is timely and accurate.

## Identifying the Parent When a Child is in Foster Care

Since the definition of “parent” provided in the proposed Part C regulations is consistent with the revised definition in the IDEA 2004 statute and with the definition of “parent” given in the final Part B regulations, the Infant & Toddler Connection of Virginia is implementing the revised definition of “parent” as detailed below. “Parent” means:

- A biological or adoptive parent of a child;
- A foster parent, unless contractual obligations with a State or local entity prohibit a foster parent from acting as a parent;
- A guardian generally authorized to act as the child’s parent, or authorized to make early intervention, educational, health or developmental decisions for the child (but not the State if the child is a ward of the State);
- An individual acting in the place of a biological or adoptive parent (including a grandparent, stepparent or other relative) with whom the child lives, or an individual who is legally responsible for the child’s welfare; or
- A surrogate parent.

If a judicial decree or order identifies a specific person or persons listed above to act as the “parent” of a child or to make health, educational or early intervention decisions on behalf of a child, then such person or persons shall be determined to be the “parent” for Part C purposes. Otherwise, the biological or adoptive parent, when attempting to act as the parent and when more than one party is qualified under the definition of “parent,” must be presumed to be the parent unless the biological or adoptive parent does not have legal authority to make educational decisions for the child. The term “parent” does not include any local or state agency, or their agents, including the Department of Social Services and their local departments, if the child is in the custody of said agency

The Office of Special Education Programs has indicated that the definition based on IDEA 2004 is not intended to be substantively different from the 1997 definition. Rather, the new definition provides clarification related to the situation in which more than one person is qualified to act as parent under the definition.

The *Code of Virginia* at § 22.1-213 adds to the IDEA definition of parent a provision addressing the situation of a child in foster care. The provision requires local school divisions to provide written notice to the child’s biological or adoptive parents at their last known address that a foster parent is acting as the parent and that the local school division is entitled to rely upon the actions of the foster parent until such time as the biological or adoptive parent attempts to act as the parent. Notice is not required if the biological or adoptive parent’s rights have been terminated. This new *Code of Virginia* requirement is **intended to prevent a delay in the provision of educational services for a child in foster care.**

Although the *Code of Virginia* language specifies the written notice requirement for local school divisions, the definition of parent under the IDEA 2004 statute applies to both Part B and Part C and will be implemented consistently in Virginia across both programs. Therefore, the local Infant & Toddler Connection system must provide the biological or adoptive parents of a child in foster care with written notice informing the biological or adoptive parent that it will deal with, and rely upon the decisions of, the foster parent for

early intervention decisions until the biological or adoptive parents “attempt to act as the parent.”

The following guidance is provided in implementing this new provision and is consistent with and based on the *Guidance Document for Implementing New Special Education Requirements for the Definition of Parent* developed by the Department of Education in May 2009.

- Timing of Notice - The required notice must be sent as soon as the system becomes aware of the foster care placement (either at referral or later during the child's enrollment in Part C if foster care placement occurs after referral). The notice is then sent again prior to each annual IFSP. In addition, the local Infant & Toddler Connection system should send any Parental Prior Notice form that goes to the foster parent to the biological/adoptive parent as well. Providing parallel notice may provide protection to the Infant & Toddler Connection system against parental allegations of a denial of rights particular to a specific event and against claims by the biological/adoptive parent that he or she has not received the written notice.
- Content of Notice - The *Notice to Biological/Adoptive Parents of a Child in Foster Care* letter must be used to provide the required notice.
- Delivery Method - The written notice may be delivered by any reasonable means including first class mail, hand-delivery or email (although email may be problematic since it could be overlooked, forwarded to spam folders, accidentally deleted, etc.). The Code of Virginia language does not specify that “address” is necessarily a residence address; therefore, an employer's address may, in some instances, qualify as a “known address.” The “last known address” requirement does not impose on the local system a duty to investigate the current whereabouts of the biological/adoptive parent if the notice directed to the last known address is returned or otherwise proves undeliverable.
- Burden of Coming Forward – Consistent with federal and state mandates, the local Infant & Toddler Connection system is not required to wait for a biological/adoptive parent to respond to the notice provided prior to relying on the actions of the foster parent. The burden of coming forward is on the biological/adoptive parent, and the local system may proceed with the foster parent in the role of parent until the biological or adoptive parent comes forward.
- Contacting DSS – Local systems are encouraged to send a copy of the notice to the child's social worker since he or she is a constant link between the child and the biological/adoptive parents while the child is in foster care and may be the best source of information related to the whereabouts of the biological/adoptive parent.
- Parent Assertion of Rights – As soon as the biological/adoptive parent notifies the local Infant & Toddler Connection of his or her intention to assert the rights of parent under IDEA, the biological/adoptive parent must be presumed to be the parent for early intervention purposes.



## **Chapter 4: Intake**

The intake process includes the initial face-to-face visit with the family and the start of information gathering for eligibility determination. This initial visit between the service coordinator and the family provides the opportunity to welcome and get to know the family, further describe the Infant & Toddler Connection system (which was introduced in the phone call with the family to schedule the visit), and discuss the options and opportunities available to them through the system. At the point of intake, the local Infant & Toddler Connection system is already beginning to provide supports and services to the family by sharing tips and information on child development and/or parenting and by providing referrals to other resources, as appropriate and with parent consent.

### The Intake Visit (The Initial Face-to-Face Visit):

#### Service Coordinator Responsibilities:

1. Meet with the family in order to share information about the Infant & Toddler Connection system. All families receive consistent information about the Infant & Toddler Connection system using the outline of topics in the box on the next page.

#### Topics to discuss with Families During the Intake Visit:

This list is intended to guide conversations and should not be read to families.

- Introduce yourself and explain that you, as their service coordinator, will assist the family during the intake and eligibility process. Let the family know that if their child is found eligible, they will always have a service coordinator who will help them obtain the services and assistance they need.
- Explain the purpose of your visit. For example, you might say, “I am here today to talk with you about the Infant & Toddler Connection of \_\_\_\_\_, to answer any questions which you might have, and to learn about your child and his/her development, your family, your activities, and to discuss what information may be needed to proceed with determining your child’s eligibility for services.”
- Explain or briefly review (if introduced in a previous conversation or through written materials) the state definition of eligibility, and explain that two providers from two different disciplines participate in the determination of eligibility. Explain that the eligibility team will be using medical record information, the results of developmental screening (if needed), and the information the family shares about their child’s activities, what is going well or not going well, to determine whether their child is eligible. Share with the family that if the existing information is not enough to determine eligibility, then additional assessment will be conducted to determine eligibility. If the family asks you if you think their child is eligible, reflect on the information that you have gathered and how that relates to Virginia’s definition of eligibility. Explain that you cannot make a definitive statement at this time. (For example: “The information I have gathered today indicates that your child appears to be at age level with his development. Let me review with you the next step in our process. With your written consent, I will be taking this information and bringing it to our early intervention team for eligibility determination. We are required to have at least two team members make a decision about eligibility. Once they have reached a decision, we will know for sure if your child is eligible or not.”)
- Explain that if their child is eligible and they wish to receive early intervention services, an Individualized Family Service Plan, which is called an IFSP for short, will be developed. Let the family know that the IFSP will list the supports and services necessary to support the family in enhancing their child’s development through everyday activities. Incorporate concepts from the principles in Chapter 1 as you talk about early intervention supports and services for eligible children and their families.
- Remind the family that the eligibility determination and development of an Individualized Family Service Plan, including an assessment to help with service planning, will occur within 45 calendar days of the day they were referred unless the family prefers to extend that timeline.
- Explain that parents and/or other caregivers are involved in each step of the process and, if their child is eligible, in each early intervention session.
- Explain that some services are available at no cost to families (eligibility determination, assessment for service planning, IFSP development, service coordination). Let the family know that they may meet the cost of remaining services through use of Medicaid or private insurance and/or by monthly payment of a fee that is determined based on their family size and income. Emphasize that no family will be denied services because of an inability to pay.
- Let the family know that all information they share with you about their child and family is kept confidential. Specifically share that any information that has been received from the referral source and the information that you are gathering today is protected by confidentiality requirements.
- Give the family the opportunity to ask questions and to share with you information that they feel is important.

2. Fully inform the family about their rights, responsibilities and procedural safeguards under Part C and complete necessary paperwork (if not already addressed during phone or other contact prior to the intake visit). Emphasize the rights and safeguards applicable to the screening and eligibility determination steps in the early intervention process.
  - a. Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.
  - b. Provide a copy and explanation of *Notice of Child and Family Rights and Safeguards in the Infant and Toddler Connection of Virginia Part C Early Intervention System* and *Strengthening Partnerships: A Guide to Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*.
  - c. Point out where information related to storage, disclosure, accessing and correcting of personally identifiable information is included in the *Notice of Child and Family Rights and Safeguards in the Infant and Toddler Connection of Virginia Part C Early Intervention System*.
  - d. Obtain informed, written parental consent to proceed to screening (if needed) and/or eligibility determination using the *Notice and Consent to Determine Eligibility* form, marking the appropriate consent statement(s) at the bottom of the form to indicate whether the family is giving consent for developmental screening, hearing and vision screening and/or eligibility determination. In some situations, it also will be appropriate to obtain informed written consent to proceed to assessment for service planning using the *Notice and Consent for Assessment for Service Planning* form. Situations in which this might be appropriate are further described later in this chapter.

Can screening occur during the intake visit even if the family signs the *Notice and Consent to Determine Eligibility* form during the intake visit? If the service coordinator is trained to conduct the screening(s), then all or parts of the Virginia hearing and vision screenings and the developmental screening may be completed during the intake visit, with parent consent. Prior to requesting parent consent to conduct the hearing, vision and/or developmental screening at the intake visit, the service coordinator must fully explain the screening activities and discuss with the family the advantages and disadvantages of proceeding with the screening on the same day versus doing so at a separate visit. Only with fully informed parent consent, indicated by initialing the Optional statement in the lower right corner of the notice and consent form, may the screening be conducted on the same day the consent form is signed.

Consider using the following language in explaining the advantages and disadvantages of completing the screening on the same day: "I am required to give you at least 5 days notice before we plan to conduct the screening. You have the option, though, to move forward immediately if you prefer. Some families like to take some time to review the activities proposed, ask questions, or talk with other family members or individuals who offer guidance and support to them before making a decision to proceed. Others feel like they understand what's being proposed and want to move ahead quickly. You should feel free to decide based on what you think is best for your family."

- e. Obtain parent signature on release of information forms in order to obtain existing screening, medical, or other information to assist in determination of eligibility.
- f. Obtain parent consent to contact the referring agency/provider and the child's primary medical care provider to inform them of the child's status in the Part C system, if consent was not already obtained by the referral source and/or primary medical care provider.
- g. If the child has Medicaid, ensure completion of the *Family Cost Share Agreement* form prior to eligibility determination (See instructions in Chapter 11). This step is necessary for timely entry of Medicaid data in ITOTS and, as a result, Medicaid reimbursement for all reimbursable services, including assessment for service planning if the child is eligible.
- h. Ask the family about the child's race/ethnicity using the federally-required 2-part question:
  - Is your child Hispanic/Latino?
  - From which of the following racial groups is your child? – American Indian or Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; or White?

Document the family's response for entry into ITOTS.

- If the family states that they do not belong to one of the given racial groups and states their race as something other than one of the given categories, then record in the contact note or on an intake form the race stated by the family. Based on the race stated by the family, enter the appropriate race category into ITOTS.
  - If the family states more than one race for their child, then all races stated must be recorded and reflected in ITOTS.
- 3. Gather information about the child's development, his health history and his medical home information. Some of this information may have been gathered during the referral call or during the call to schedule the intake visit. In that case, use the intake visit to document any additional information needed for eligibility determination.
  - a. Begin a conversation with the family that lets you get to know the child and his family and their activities, and that will be used for the purpose of eligibility determination. If the child is found eligible, this information will also be helpful in completing the family assessment and for IFSP development. Conversation starters may include, but are not limited to, the following:
    - Tell me about your family - who is in your family.
    - Who are the other caregivers for Johnny, e.g., extended family, child care providers, etc.
    - Tell me about the places your child and family spend time.
    - What is a typical day like for your child and family?
    - Tell me about your routines/activities. Which routines/activities are going well and which are not?
    - What other activities would you like your child and family to participate in?
    - What activities really interest your child, and which ones interest you to do with your child?

This list of suggested conversation starters is not presented in any particular order, and there is no requirement that they be worded as written.

- b. Ensure the following screenings have been or are conducted. When conducted after referral to the Infant & Toddler Connection System, these screenings may be conducted by any certified Early Intervention Professional, Early Intervention Specialist or Early Intervention Service Coordinator trained to conduct the screening.
  - Hearing and vision screening, with the *Virginia Part C Hearing Screening* and *Virginia Part C Vision Screening* forms completed.
    - 1) Parent consent for hearing and vision screening may be documented on the *Notice and Consent to Determine Eligibility* form or on the *Notice and Consent for Assessment for Service Planning* form depending on the timing of the hearing and vision screening.
    - 2) If the child has a diagnosed condition or an obvious delay or atypical development that will make the child eligible, then it is not necessary to complete the hearing and vision screening prior to eligibility determination. Under these circumstances, the hearing and vision screening may be completed as part of the assessment for service planning instead.
    - 3) The Virginia Part C Hearing Screening and Virginia Part C Vision Screening may be conducted by any practitioner, including service coordinators, trained to conduct the screening.
    - 4) If the family gives consent for hearing and vision screening on the *Notice and Consent to Determine Eligibility* form, the family may later agree to wait and complete the hearing and vision screening at the assessment for service planning, as long as their child has a diagnosed condition or an obvious delay or atypical development that will make the child eligible and as long as the decision to wait is documented in a contact note.
    - 5) No child may be found ineligible for Part C without having the hearing and vision screenings completed.
  - A developmental screening using a tool unless there is (1) a diagnosed physical or mental condition with a high probability of resulting in developmental delay, (2) documented developmental delay or atypical development, or (3) the child has already received a developmental assessment or screening prior to referral.
    - 1) Developmental screening may be conducted by practitioners certified as early intervention professionals and by those certified as early intervention specialists or early intervention service coordinators who have been trained to conduct screening.
    - 2) For those children who must receive a developmental screening using a tool (those who do not fall into one of the three exceptions listed above), it is acceptable to first screen in the area of the suspected delay or atypical

development. If screening in that area(s) indicates the child will be eligible for Part C, then it is not necessary to screen in the remaining areas of development. Otherwise, the child must be screened in all areas of development. In either case, the provider conducting the screening must actually see the child in order to complete the screening.

- 3) No child may be found ineligible for Part C without having a developmental screening completed in all areas of development.
- 4) The following comprehensive developmental screening tools are strongly recommended for use in the Infant & Toddler Connection of Virginia: Parents' Evaluation of Developmental Status (PEDS), Ages and Stages Questionnaire (ASQ), and Bayley Infant Neurodevelopmental Screen (BINS). These recommendations are based on the review of research and resulting recommendations presented in "Pediatric Developmental Screening: Understanding and Selecting Screening Instruments" (2008). This manual can be accessed at <http://commonwealthfund.org/Content/Publications/Fund-Manuals/2008/Feb/Pediatric-Developmental-Screening--Understanding-and-Selecting-Screening-Instruments.aspx>.

#### Screening tools for very young infants

**Question:** What screening instrument do we use for a child who is less than 1 month old since the ASQ does not screen birth to 1 month?

**Answer:** Information from a variety of resources can be used to compare the child's development to what is expected for a child who is less than one month old, including online developmental websites, print resources, and relevant sections of developmental assessment tools. Screening should include identification of potential atypical development such as issues with tone and posture, sleep, feeding and self-regulation.

- c. Document, in a contact note(s) or through other written means, the information shared by the family and gathered through screening and observation so this information can be shared with other team members during eligibility determination, assessment for service planning and IFSP development. This promotes timely and accurate communication and minimizes the number of times the family needs to share the same information. Since this information will be used by the Eligibility Determination team, the documentation needs to clearly communicate to individuals who were not present at the intake visit what the service coordinator and/or other provider observed about the child's development

- and learned through screening and/or parent report.
- d. If the referral was not from the child's primary medical care provider, then request the name of that provider from the family. If the child does not have a primary medical care provider, then offer assistance to the family in obtaining a primary care provider for their child. For example, assistance can be provided by giving the family a listing of area physicians and their phone numbers. The family cannot be required to obtain a primary care doctor in order to access Part C early intervention services.
  - e. Arrange to assist the family in completion of a Medicaid application or applications for other programs and supports, as needed. The family cannot be required to apply for Medicaid in order to access Part C early intervention services.
4. Let the family know when their child's eligibility determination will be made and how the information provided by the family will be used in that determination.
    - a. Local systems have the option to invite the family to participate further in the eligibility determination process by phone, in writing or through a meeting, depending on how the eligibility process works in the local system and what makes sense for this specific child and family.
    - b. If the family will not participate in the eligibility discussion then explain that you will call them following the determination to inform them of the decision.
    - c. If the referral information or information gathered during intake indicates the child has a diagnosed condition that meets Virginia's eligibility criteria (see Chapter 5), explain to the family that they may want to combine the eligibility determination and assessment for service planning steps since eligibility can be quickly confirmed by the review of existing documentation at the same time assessment is conducted. Be sure to explain the purpose of both steps in the process and obtain parent consent for both eligibility determination and assessment for service planning. Since the financial intake must be completed prior to IFSP development, if the family wishes to combine the eligibility determination with the assessment for service planning (and potentially the IFSP meeting), then talk with the family about completing the financial intake prior to the combined activities to ensure the financial information can be discussed privately.
  5. If the family declines screening or the family decides not to proceed to eligibility determination:
    - a. Provide a copy and explanation of the *Declining Early Intervention Services* form and the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*.
      - Make reasonable efforts to ensure the family understands the screening and eligibility determination services that are available, that these services are provided at no cost to the family, and that these services cannot be provided without parental consent.
      - Using the bottom half of the *Declining Early Intervention Services* form, the family is asked to mark the first line (that they understand that eligibility determination may be conducted and that they do not choose to have their child receive an eligibility determination).

- In explaining the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
- Explain how to access Part C services in the future, pointing out the contact number provided at the bottom of the *Declining Early Intervention Services* form.
- If the child is close to being age eligible for early childhood special education services through the local school division (under Part B), explain how to access Part B services through the local school division.
- Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.
- Obtain parent consent to communicate with the primary care physician and the primary referral source, if not already provided.
- Document in ITOTS within 10 business days of the family declining to proceed that eligibility determination was not completed for the child and that the reason was the family declined eligibility determination.

#### Other Intake Activities Following the Intake Visit:

##### Service Coordinator Responsibilities:

1. Request existing screening, medical and other information to assist in eligibility determination, if not already requested.
  - a. Medical information requested should be specific to eligibility determination and service planning (e.g., diagnostic information and developmental screening and assessment results). A full medical record is generally not necessary or appropriate.
  - b. Service coordinators are expected to make every effort to obtain physician and other appropriate records prior to eligibility determination, following up on initial requests with actions such as phone calls to request a fax of the needed records, going to the physician's office to pick up copies, or collecting the information via a telephone call with a hard copy received later for inclusion in the child's record.
    - How quickly the service coordinator follows up after an initial request for medical or other records may depend on the extent to which those records are needed in order to determine eligibility.
    - Eligibility determination should not be delayed to wait for medical records unless other information gathered through intake or through intake plus assessment for eligibility is insufficient to determine and document the child's eligibility.
    - Remember that in some situations (e.g., with premature infants) the medical information will be very important in ensuring the



eligibility determination team has complete information to consider since informed clinical opinion can be used to determine a child eligible even when screening or assessment instruments or other information does not establish that eligibility.

- Also keep in mind that these records may be helpful to the team that is conducting the assessment for service planning and to the IFSP team even if they are not needed for eligibility determination.

#### ITOTS Data Entry – Intake

The local system manager ensures the following data is entered into ITOTS:

1. Child's race/ethnicity
2. If the family declines to proceed to eligibility determination, then mark Eligibility Determination Completed as No and mark the appropriate box for the reason (Unable to contact, deceased, declined screening, declined eligibility determination)

[Complete ITOTS instructions are available at

<http://www.infantva.org/documents/forms/INST1117eR.pdf>]

#### Local Monitoring and Supervision Associated with Intake:

The local system manager provides the supervision and monitoring necessary to ensure the following:

1. Procedural safeguards forms are used and explained appropriately.
2. Consistent and accurate information is provided to the family during the intake visit.
3. There are timely requests and follow-up to receive medical and other records for eligibility determination.
4. Qualified personnel and approved screening tools are used in conducting developmental, hearing and vision screening.
5. The intake visit occurs quickly enough after referral to allow time for eligibility determination, assessment for service planning and IFSP development to occur within the 45-day timeline.
6. ITOTS data entry is timely and accurate.

## Chapter 5: Eligibility Determination

Eligibility determination is the process by which a multidisciplinary team reviews medical reports, developmental screening results, parent report, observation summaries, and assessment reports, if available, to determine whether or not a child meets the Infant & Toddler Connection of Virginia eligibility criteria. Assessments are conducted as part of the eligibility determination process only if a child's eligibility is uncertain based on existing information, and those assessments then become part of the information used by the multidisciplinary team to determine eligibility.

### Virginia Part C Eligibility Criteria

Infants and toddlers, birth to three years old, and their families are eligible for early intervention supports and services through the Infant & Toddler Connection of Virginia if the multidisciplinary team determines, through the practices described in this chapter, that the child meets one or more of the following criteria:

1. Developmental Delay – Children who are functioning at least 25% below their chronological or adjusted age in one or more of the following areas:
  - a. Cognitive development;
  - b. Physical development, including fine motor and gross motor;
  - c. Communication development;
  - d. Social or emotional development; or
  - e. Adaptive development.

For children born prematurely (gestation < 37 weeks), the child's adjusted age is used to determine developmental status. Chronological age is used once the child is 18 months old.
2. Atypical development – Children who manifest atypical development or behavior, which is demonstrated by one or more of the following criteria (even in the absence of a 25% developmental delay):
  - a. Atypical or questionable sensory-motor responses (listed in ITOTS as “Abnormal or questionable sensory-motor responses”), such as:
    - Abnormal muscle tone;
    - Limitations in joint range of motion;
    - Abnormal reflex or postural reactions;
    - Poor quality of movement patterns or quality of skill performance;
    - Oral-motor skills dysfunction, including feeding difficulties.
  - b. Atypical or questionable social-emotional development (Listed in ITOTS as “Identified Affective Disorders”), such as:
    - Delay or abnormality in achieving expected emotional milestones;
    - Persistent failure to initiate or respond to most social interactions;
    - Fearfulness or other distress that does not respond to comforting by caregivers.
  - c. Atypical or questionable behaviors that interfere with the acquisition of developmental skills (Listed in ITOTS as “Behavioral disorders that interfere with acquisition of developmental skills”).
  - d. Impairment in social interaction and communication skills along with restricted and repetitive behaviors.
3. Children with a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. These conditions include, but are not limited to the following:
  - a. seizures with significant encephalopathy;
  - b. significant central nervous system anomaly;

- c. severe Grade 3 intraventricular hemorrhage with hydrocephalus or Grade 4 intraventricular hemorrhage;
- d. symptomatic congenital infection;
- e. effects of toxic exposure including fetal alcohol syndrome, drug withdrawal and exposure to chronic maternal use of anticonvulsants, antineoplastics, and anticoagulants;
- f. meningomyelocele;
- g. congenital or acquired hearing loss;
- h. visual disabilities;
- i. chromosomal abnormalities, including Down syndrome;
- j. brain or spinal cord trauma, with abnormal neurologic exam at discharge;
- k. inborn errors of metabolism;
- l. microcephaly;
- m. severe attachment disorders;
- n. failure to thrive;
- o. autism spectrum disorder;
- p. endocrine disorders with a high probability of resulting in developmental delay;
- q. hemoglobinopathies with a high probability of resulting in developmental delay;
- r. cleft lip or palate; or
- s. other physical or mental conditions at the multidisciplinary team members' discretion.

**Children may not receive services on or after their third birthday.**

Additional explanation of the eligibility categories is provided at the end of this chapter.

#### Planning and Preparation for Eligibility Determination

##### Service Coordinator Responsibilities:

1. Assemble documentation that will be used in eligibility determination, including results of any screenings completed, medical information, parent report, formal/informal observation and written assessment reports if available.
2. Facilitate identification of the multidisciplinary team that will determine eligibility and coordinate scheduling of the eligibility determination meeting, if needed.
  - a. The multidisciplinary team must be comprised of professionals from at least 2 different disciplines and the service coordinator. There is no requirement that the disciplines on the team match the areas of concern for the child.
  - b. It is possible that one or more disciplines were involved in conducting screening and/or assessment prior to referral that may be used for eligibility determination. A written report by this individual is enough to count towards the requirement for 2 disciplines to participate if (1) the report or cover letter states that this individual believes the child is eligible for Part C based on \_\_\_\_\_ (developmental delay, atypical development or diagnosed condition as evidenced by \_\_\_\_); or (2) the report states the child's level of development or percent of delay, or gives the diagnosed condition, or states the presence of atypical development; or (3) the report gives enough specific data about the child's skills that the other team member can determine that the child has at least a 25% delay in one or more areas of development or atypical development.

- c. The service coordinator may only serve as one of the disciplines if he or she is also a qualified practitioner in a discipline other than service coordinator (e.g., the service coordinator is also a speech-language pathologist who is certified as an Early Intervention Professional). In that situation, the service coordinator may participate on the multidisciplinary team in the dual function as one discipline and as the service coordinator.
- d. Eligibility determination team members may communicate through a face-to-face meeting, phone call, email, fax, video conference, or other electronic means. Face-to-face meetings may take place in office settings, in a family's home or in other locations as determined by the team. Although eligibility determination does not require a face-to-face meeting, it must be planned ahead of time to allow team members adequate opportunity to review available information.
- e. All families participate in the eligibility determination process by sharing information during intake that is reviewed by the multidisciplinary team and used in determining eligibility. The family may be invited to participate further in the process by phone, in writing or through a meeting, depending on how the eligibility process works in the local system and what makes sense for this specific child and family.

**Question:** Suppose medical records contain information that verifies a child has a diagnosed condition. Can the service coordinator, if he/she meets the criteria for another discipline, determine eligibility with the family at the intake visit after the *Notice and Consent to Determine Eligibility* form is completed?

**Answer:** Yes, as long as the following conditions are met:

- The service coordinator is certified as an Early Intervention Professional in addition to an Early Intervention Service Coordinator;
- Documentation of the diagnosed condition has been received from the physician;
- The family has initialed the 5-day box at the bottom of the *Notice and Consent to Determine Eligibility Form*; and
- The diagnosed condition is not an endocrine disorder or a hemoglobinopathy. Not all disorders within these two categories have a high probability of resulting in developmental delay for all children. Therefore, with these diagnoses the documentation from or a discussion with the physician would need to specifically indicate that this condition has a high probability of resulting in delay for this child, or a second discipline would need to participate in the eligibility determination along with the service coordinator/EI Professional.

### Determining Eligibility

#### General:

1. During eligibility determination, it is not necessary to determine the child's specific age level in each area of development. The multidisciplinary team must only be able to state whether the child has a developmental delay (at least 25% in one or more areas of development), atypical development or a diagnosed condition that meets Virginia's eligibility criteria. Eligible children will move on to

- assessment for service planning, and that assessment information combined with the information used to determine eligibility will allow the team to describe on the IFSP the child's status (current level of functioning) in each area of development. The current level of functioning required on the IFSP does not have to be an age level or range but may be a description of the child's functional skills in that area of development.
2. A child referred from another local Infant & Toddler Connection system within Virginia who has already been determined eligible does not need to be found eligible again and may move directly to assessment for service planning, IFSP development or IFSP implementation (with an IFSP review) depending on how far into the early intervention process the family was with the sending local system.
  3. If a child was previously enrolled in the Infant & Toddler Connection system but has been out of services for 6 months or longer or is currently enrolled but has been lost to contact for 6 months or more, then the local system must conduct a new eligibility determination and assessment for service planning, establish new entry ratings on the child indicators (if the child is still 30 months old or younger), and establish a new IFSP before resuming services. If a child has been out of services for less than 6 months, then it is only necessary to conduct a new eligibility determination if there is an indication of a significant change in the child's developmental status.
  4. For children referred with an eligibility determination and/or an IFSP from another state, eligibility must be established in Virginia prior to proceeding to IFSP development and implementation. Existing information, such as medical records, developmental screening results, parent report, observation and available assessment results, will be used for eligibility determination. If there is insufficient medical and developmental information from within the past 6 months to determine eligibility, then a new developmental screening may be conducted. The results of that developmental screening, along with parent report and observation may then be used for eligibility determination. The service coordinator will ask the family for consent to request the early intervention records from the sending state.
  5. The annual IFSP meeting includes confirmation of ongoing eligibility. This is required regardless of the reason for initial eligibility (i.e., annual confirmation is required even if the child was found eligible based on a diagnosed condition). The determination of ongoing eligibility is made based on the progress reports of team members and/or review of contact notes, not through formal testing. The progress report may be written or may be a verbal report based on contact notes. The child's eligibility status at the time of the annual IFSP is documented on the *Eligibility Determination Form*. Further information on the annual determination of eligibility, including procedural safeguards requirements associated with this step, is provided in the "Annual IFSP" section of Chapter 8.
  6. If, prior to the annual IFSP meeting, the family or another IFSP team member(s) believes the child has reached age level in all areas of development and shows no sign of atypical development (and does not have a diagnosed condition), then an IFSP review is held to determine ongoing eligibility. Eligibility determination can occur during the IFSP review meeting (as long as 2 disciplines participate). Details on determining eligibility in this situation are provided in the "IFSP Reviews" section of Chapter 8.

#### Multidisciplinary Team Responsibilities:

1. Focus solely on whether or not the child meets Virginia's eligibility criteria. The assessment for service planning team will gather the information necessary to determine what supports and services an eligible child needs.
2. Review available documentation to determine whether the child has a diagnosed condition that meets the Virginia criteria for a physical or mental condition with a high probability of resulting in developmental delay. In order for a child to be determined eligible based on a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay, there must be documentation that the condition has been diagnosed by a professional qualified to make the diagnosis. Remember that endocrine disorders and hemoglobinopathies make the child eligible under Part C in Virginia only if the multidisciplinary team determines that the diagnosis has a high probability of resulting in developmental delay for this specific child since not all disorders within these categories have a high probability of resulting in developmental delay for all children.
  - a. When referral information or information gathered at intake indicates the child has a diagnosed condition that meets Virginia eligibility criteria, it makes sense to combine eligibility determination with assessment for service planning, with parent consent.
3. If the child does not have a diagnosed condition that meets Virginia's eligibility criteria, determine whether the child is eligible based on a developmental delay or atypical development as defined earlier in this chapter.
  - a. Review pertinent records less than six (6) months old from the primary care physician and other sources related to the child's current health status, physical development (including vision and hearing), and medical history, or arrange for participation by the primary health care provider(s). Other records pertinent to eligibility determination, such as birth records, newborn screening results and early medical history, also should be reviewed by the team (with parent consent), even if those records are more than six (6) months old. Document in the child's early intervention record if the parent(s) chose not to consent to a review of records or if requested records were not received in time for review for eligibility determination, despite a timely request and follow-up.
    - Eligibility determination should not be delayed to wait for medical records unless other information gathered through intake or through intake plus assessment for eligibility is insufficient to determine and document the child's eligibility.
  - b. Consider the results of any developmental screening completed, parent report, formal/informal observation, and any available written assessment reports.
  - c. Use informed clinical opinion – Informed clinical opinion is the result of synthesizing medical and developmental information (based on a tool, observation, parent report, medical records, etc.) with professional expertise and experience to make a determination regarding a child's developmental status and/or eligibility. Informed clinical opinion may be the basis upon which the eligibility determination is made. This does not violate the requirement (below) that no single procedure be the sole criterion for determining a child's eligibility since the informed clinical opinion would be based on multiple procedures and sources of information. **Informed clinical opinion may be used to establish a**

- child's eligibility even when screening or assessment instruments or other information does not establish that eligibility.** However, informed clinical opinion cannot be used to negate eligibility established through the use of appropriate assessment instruments or procedures.
- d. Ensure that no single procedure is used as the sole criterion for determining a child's eligibility – By looking at the multiple sources of information available for eligibility determination (e.g., medical records, developmental screening results, information from formal/informal observation, parent report, etc.) the multidisciplinary team ensures that the eligibility determination is based on more than one procedure.
4. If existing information is insufficient to determine the child's eligibility under Part C, then determine the appropriate provider(s) to carry out any assessment activities necessary for eligibility determination.
    - a. In this situation, it is recommended that any assessment needed to determine eligibility be combined with assessment for service planning, with parent consent. It is not necessary for the multidisciplinary team to meet again, as a separate activity, to determine eligibility before proceeding to assessment for service planning.
    - b. In combining the assessment for eligibility determination and assessment for service planning, the multidisciplinary team is expected to consider how the assessment can proceed in such a way that, if it becomes clear that the child does not meet eligibility criteria, then a full assessment for service planning is not completed. For example, if the area of concern (based on referral information, screening, observation and parent report) is language then begin the assessment by focusing on that area of development.
  5. Complete the *Eligibility Determination Form*.
    - a. Complete the information at the top of the form: Child's Name, Date of Birth, Age/Adjusted Age, Parent's Name, and Service Coordinator's Name
    - b. Mark whether this is an initial, annual, or interim eligibility determination.
    - c. Record the date of eligibility determination. Use the date that eligibility was determined, even if that occurred on the same date as the assessment for service planning (Medicaid will still reimburse for the assessment for service planning in this situation).
    - d. Mark whether the child was determined eligible or not eligible
    - e. If the child is eligible, check off all criteria on which that eligibility was based (e.g., developmental delay and/or atypical development and/or diagnosed condition). If the child has a diagnosed condition(s), mark the specific condition(s) in the next section of the form. Note: The *Eligibility Determination Form* should reflect only those reasons for eligibility identified as of the date of eligibility determination. Additional reasons for eligibility may be discovered during the assessment for service planning, and these will be documented elsewhere, not on this form.
    - f. Use the Methods and Documents section of the form to check off all of the methods and documents that were used and reviewed in making the eligibility determination. If a comprehensive developmental screening was completed, identify the person who completed the screening and the screening tool used.
    - g. Complete the Eligibility Narrative. The information provided in this section should be detailed enough that someone who was not a member of the

team could read the form and understand why the child was found eligible/not eligible. The Eligibility Narrative section will automatically expand onto the next page when the form is completed electronically. When completing the form by hand, it may be necessary to continue on the back of the page or on an attached page.

- h. Identify the members of the eligibility determination team and their method of participation. Typed names or electronic signatures are permitted in lieu of handwritten signatures.
- i. Although age levels or ranges are not required in order to determine eligibility, these may be recorded on the *Eligibility Determination Form*, in contact notes, and/or on screening or assessment instruments that are maintained in the child's record if age levels or ranges were identified for some or all areas of development.

#### Service Coordinator Responsibilities:

1. Participate in the determination of eligibility by sharing information from the family and from any screening and/or observation completed by the service coordinator. This information may be shared in writing or verbally (based on contact notes). This may occur face-to-face with other team members, by phone or other electronic means, or in writing.
2. Share results of the eligibility determination process with the family, including a copy of the completed *Eligibility Determination Form*. This information may be shared with the family in person or by phone (with the form faxed, mailed or handed to the family at the next contact). Facilitate an opportunity for the family to talk with the eligibility determination team if the family has questions about the eligibility finding and if desired by the family.
3. If the child is eligible, then schedule a visit or phone contact(s) with the family, as needed, to discuss and plan for assessment for service planning and the IFSP meeting. Remind the family that the eligibility determination team's job was to determine whether there was any delay, atypical development or diagnosed condition that would make their child eligible. Explain that the assessment for service planning will help to identify whether there are any other areas of delay or concern beyond those identified during eligibility determination, as well as highlighting their child's areas of strength and interest.
4. If the child is eligible but the parents decline to proceed, then
  - a. Provide a copy and explanation of the *Declining Early Intervention Services* form and the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*.
    - Using the bottom half of the *Declining Early Intervention Services* form, the family is asked to mark the second line (that they understand that an IFSP can be developed for their child/family and that they do not choose to have their child receive an IFSP). Explain to the family how they can contact the local Infant & Toddler Connection system in the future using the phone number provided at the bottom of the form if they have concerns about their child's development.
    - In explaining the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*, review and explain the complaint procedures. Even if the family has already received a copy of the



Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

- b. Explain how to access early childhood special education services through the local school division (under Part B) if the child is close to being age eligible for Part B services.
- c. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.
- d. Attempt to obtain parent consent to communicate with the primary care physician and primary referral source, if not already provided. It is also acceptable to give the family the option to notify their physician themselves.

Talking with the Family About Notifying the Physician:

Consider using the following language in seeking parent permission to notify the physician: "It's important to let your physician know that your child will not be receiving early intervention services so he/she can continue to keep an eye on your child's development. We can do that if you'll give us written consent (which we can do by mail). If not, we would ask that you let your physician know yourself."

- e. Document in ITOTS, within 10 business days of the family declining services, that eligibility determination was completed and that either the child was eligible/declined services or eligible/chose other services.
5. If the child is ineligible:
- a. Provide the parents with a copy and explanation of the *Parental Prior Notice* form (indicating "Your child is not eligible for Infant & Toddler Connection of Virginia") and the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*. On the *Parental Prior Notice* form, identify the information used to make the determination that the child is not eligible. In explaining the Notice of Child and Family Rights and Safeguards, the service coordinator reviews and explains the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
  - b. For Medicaid recipients only: Complete and provide the family with the *Early Intervention Services – Notice of Action* letter and explain to the family their right to appeal under Medicaid if they disagree with the multidisciplinary team's determination that their child is not eligible for early intervention services. Point out where additional information about the appeal process is located in the *Notice of Child and Family Rights and*

*Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System.*

- c. Facilitate an opportunity for the family to talk with the eligibility determination team if the family has questions or disagrees with the eligibility finding and if desired by the family.
  - d. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.
  - e. Document in ITOTS, within 10 business days of completing eligibility determination, that eligibility determination was completed and that the child is not EI eligible.
6. Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.
  7. Document in the child's early intervention record any and all circumstances that result in a delay in eligibility determination.

Interim IFSP

General:

1. An interim IFSP may be developed and implemented for an eligible child in those exceptional circumstances where there is an obvious and immediate need for services to begin before the team has completed the assessment for service planning and developed the IFSP. These situations should be the exception rather than the rule. When an interim IFSP is needed, its purpose is to document those services that are needed immediately, as well as the parent's consent for those services to begin.
2. The use of an interim IFSP does not negate the requirement to develop an initial IFSP within 45 calendar days of referral. Rather, the interim IFSP allows essential services to begin while the team completes the remaining steps for developing the initial IFSP.
3. If there are exceptional circumstances that make it impossible to complete assessment for service planning and IFSP development within the 45-day timeline, then these circumstances must be documented in the child's record. An interim IFSP may be used for an eligible child in this situation, as appropriate to address immediate needs. One situation in which an interim IFSP may be appropriate would involve an eligible child who is medically fragile or experiencing a medical crisis who is currently unable to undergo necessary assessment or whose family is unable to participate in an IFSP meeting but for whom there is an immediate need for early intervention services. The use of an interim IFSP in this situation allows for needed services to begin while also allowing the child and family to wait until a more appropriate time to complete the assessment for service planning and IFSP development.

Service Coordinator Responsibilities:

1. Ensure the eligibility determination process is completed and the child found eligible prior to development of an interim IFSP.
2. Develop the interim IFSP jointly with the family and with input from the multidisciplinary team. Input from the multidisciplinary team members may be provided in person, by phone or other electronic means or in writing. The interim IFSP must include:

- a. The name of the service coordinator who is responsible for implementation of the interim IFSP and coordination with other agencies and persons;
- b. The early intervention supports and services that are needed immediately by the child and the child's family. Specify the frequency, intensity, group/individual, location, method, and potential payment source(s) for each service; and
- c. Signatures of both the service coordinator and the parent(s).

There is no requirement to use pages or sections from the statewide IFSP form in developing an interim IFSP.

3. Facilitate the timely start of services identified on the interim IFSP. Although the services must begin within 30 calendar days of the date the family signs the interim IFSP, because services on an interim IFSP have been identified based on an immediate need these services should begin right away and certainly in much fewer than 30 days.
4. Ensure that assessment for service planning and development of the initial IFSP still occur within 45-calendar days of referral and that any circumstances resulting in a delay in development of the IFSP are fully documented in the child's record.

#### ITOTS Data Entry – Eligibility Determination

Following eligibility determination, the local system manager ensures that the following data is entered into ITOTS within 10 business days of the eligibility determination:

1. Eligibility determination completed? Yes or No
  - a. If no, reason not completed
  - b. If yes, date of eligibility determination
2. EI Eligible? Yes or No
3. Result of eligibility determination
4. Medicaid information (Medicaid/FAMIS coverage selected from the dropdown menu under Third Party Coverage and an accurate 12-digit Medicaid number entered) for children who have Medicaid. Please see the box on the next page for additional information about data entry for enrollment in the Medicaid EI benefit.

[Complete ITOTS instructions are available at

<http://www.infantva.org/documents/forms/INST1117eR.pdf>]

#### Local Monitoring and Supervision Associated with Eligibility Determination

The local system manager provides the supervision and monitoring necessary to ensure the following:

1. There is timely request for and follow-up to receive existing records for use in eligibility determination.
2. Assessment is carried out for eligibility determination only if the multidisciplinary team finds that existing information is insufficient to determine eligibility.
3. Determination of eligibility occurs quickly enough after referral to allow time for assessment for service planning and IFSP development to occur within the 45-day timeline.
4. Eligibility determination is completed by a multidisciplinary team comprised of professionals from at least 2 different disciplines and the service coordinator.
5. Providers participating in eligibility determination have a complete and accurate understanding of Virginia's eligibility criteria.

6. The *Eligibility Determination Form* is accurately completed and reflects the necessary information to support the decision of the individuals determining eligibility (i.e., all sections of the form are completed, including the signatures/names of team members, and the narrative is detailed enough that someone who was not a member of the team could read the form and understand why the child was found eligible/not eligible).
7. There is timely and accurate entry of ITOTS data.
8. The monthly Medicaid Enrollment Report, Change Report and Claims Report are reviewed and the Part C Office is notified of any discrepancies between the Medicaid reports and the local information to ensure Medicaid EI enrollment is correct.

**Initial Data Entry for Enrollment in Medicaid EI Benefit:**

When the Department of Behavioral Health and Developmental Services (DBHDS) provides the Department of Medical Assistance Services (DMAS) with a list of children who are dually enrolled in Part C and in Medicaid, that data is pulled solely from the Medicaid line item in ITOTS under Third Party Health Coverage. Therefore, in order for providers to receive Medicaid reimbursement for Part C early intervention services the following ITOTS data fields must be completed promptly and accurately:

- The check box next to Medicaid must be marked; and
- An accurate 12-digit Medicaid number must be entered in the ID field next to Medicaid. The 12-digit number is adequate documentation for DMAS to determine whether the child is enrolled in fee for service, FAMIS or an MCO.
- Eligibility Determination Completed is marked “yes”
- Date (of eligibility determination) is completed
- EI Eligible is marked “yes”

**Child has Medicaid/FAMIS when Part C Eligibility Determined**

- ITOTS data entry must be complete within 10 business days of the date for “eligibility determination completed” when EI Eligible is “yes” in order for the Medicaid/FAMIS Early Intervention benefit to start on the date of Assessment for Service Planning.
- If the required information is entered in ITOTS more than 10 business days after the date for “eligibility determination completed,” then the date the required information is entered in ITOTS will be the start date for the Medicaid Early Intervention benefit.

**Child Enrolled in Medicaid/FAMIS after Part C Eligibility Determined**

- If Medicaid/FAMIS is selected and the 12-digit Medicaid number is entered in ITOTS within 10 business days of the date that the Medicaid/FAMIS eligibility was determined, then the start date for the Medicaid EI benefit is the same as the Medicaid/FAMIS start date, unless this date precedes the Part C Eligibility Determination date. If the Medicaid/FAMIS start date precedes the Part C Eligibility Determination Date, then the Part C Eligibility Determination Date will be the start date for the Medicaid EI benefit.
- If Medicaid/FAMIS is selected and the 12-digit Medicaid number is entered more than 10 business days after the date that the Medicaid/FAMIS eligibility was determined, then the date the required information was entered in ITOTS will be the start date for the Medicaid EI benefit. Neither Medicaid nor Part C reimbursement will be available for the time period that is not covered.

## Interpretation of Eligibility Criteria for Part C

The following information is designed to provide interpretation of the criteria used in determining eligibility for Virginia's Part C Program.

### Developmental Delay:

**≥ 25% deficit based on adjusted age:** adjusted age is determined by subtracting actual gestational age (weeks) at birth as determined by expected date of confinement (EDC, i.e., due date) or Dubowitz (or Ballard, a modification of the Dubowitz exam) from 40 weeks (normal term gestation). This value is then added to the actual birth date to determine the adjusted birth date. For example, an infant born at 36 weeks is 4 weeks early. If the birth date is 1/12/96, the adjusted birth date would be 4 weeks from the date, or February 8, 1996.

**Cognitive development** refers to intellectual development

**Fine motor** refers to use of the hands, and hand-eye coordination

**Gross motor** refers to locomotion, and the ability to move and support oneself (sit, roll, walk)

**Speech and language** refer to the development of both expressive and receptive speech

**Social-emotional** includes behavioral responses, interpersonal skills

**Adaptive** includes the ability to care for oneself

Atypical development: Refers to patterns of development that are clearly abnormal but do not necessarily result in a developmental deficit of 25%.

**Atypical or questionable sensory-motor responses** (listed in ITOTS as “Abnormal or questionable sensory-motor responses”), such as abnormal muscle tone; limitations in joint range of motion; abnormal reflex or postural reactions; poor quality of movement patterns or quality of skill performance; atypical articulation\*; or oral-motor skills dysfunction, including feeding difficulties.

**Atypical or questionable social-emotional development** (Listed in ITOTS as “Identified Affective Disorders”), such as delay or abnormality in achieving expected emotional milestones; persistent failure to initiate or respond to most social interactions; or fearfulness or other distress that does not respond to comforting by caregivers.

**Atypical or questionable behaviors that interfere with the acquisition of developmental skills** (Listed in ITOTS as “Behavioral disorders that interfere with acquisition of developmental skills”).

**Impairment in social interaction and communication skills along with restricted and repetitive behaviors**

\* A note about articulation issues: A review of journal articles indicates that articulation issues may be considered atypical development or a delay in language development. Therefore, using either category of eligibility is acceptable. The eligibility determination team should use their informed clinical opinion to determine whether a child's articulation issues fall into atypical development or developmental delay. If the child is determined eligible due to atypical development, then articulation falls into the sensory-motor category.

Diagnosed Conditions with High Probability of Resulting in Delay:

**Seizures with significant encephalopathy:** Seizures must be accompanied by evidence of alterations in brain function that impair normal mentation and responses to stimulation such as coma, hallucinations.

**Significant CNS anomaly:** This refers to an anatomical abnormality that is known to be associated with future developmental abnormalities such as agenesis of the corpus callosum, hydrocephalus, encephalocele.

**Grade III IVH with hydrocephalus:** Grade III intraventricular hemorrhage is defined as blood in the ventricles with evidence of ventriculomegaly. Hydrocephalus refers to enlargement of the ventricles that develops as a complication of the bleed and is felt to be due to abnormal reabsorption of cerebrospinal fluid. The hydrocephalus may be static or may increase requiring intervention.

**Grade IV IVH:** A grade IV bleed is defined as both a bleed into the ventricles and a bleed into the parenchyma of the brain itself. These may or may not be associated with hydrocephalus. The area of intra parenchymal bleed normally results in necrosis of brain cells and will ultimately be a porencephalic cyst or empty space.

**Congenital infection, symptomatic:** This refers to an infection that developed in utero and may manifest at birth, in infancy, or in childhood. The most common diseases in the category are the TORCHS infections; toxoplasmosis, rubella, CMV, herpes, syphilis. The word symptomatic means that there are stigmata of the infections on exam which may include growth retardation, abnormal blood studies and/or organ involvement.

**Toxic exposure, in utero to include fetal alcohol syndrome, drug withdrawal, and others (anticonvulsants, anticoagulants):** In these cases there must be evidence of an abnormality in the infant that is a direct result of the toxic exposure.

**Meningomyelocele:** This term is synonymous with spina bifida.

**Hearing loss:** Any degree of hearing loss (unilateral, bilateral, mild, moderate, severe) makes the child eligible. Hearing loss must be diagnosed by a licensed audiologist.

**Visual disabilities:** The diagnosis of visual impairment must be made by an ophthalmologist.

**Chromosomal abnormality:** This includes any diagnosed abnormality of chromosome number or length.

**Brain/spinal cord trauma with abnormal exam at discharge:** Trauma to these areas could include such diagnoses as hemorrhage, swelling. In this instance there must be continued evidence of neurologic dysfunction at the time of discharge to qualify.

**Inborn error of metabolism:** These diseases are rare and are diagnosed with special tests, including those conducted through the Virginia Newborn Screening Services program. These include:

- Argininosuccinic acidemia (ASA);
- Beta-Ketothiolase deficiency (BKT);
- Biotinidase deficiency (BIOT);

- Carnitine uptake defect (CUD);
- Citrullinemia (CIT);
- Congenital adrenal hyperplasia (CAH);
- Congenital hypothyroidism (CH);
- Cystic fibrosis (CF);
- Galactosemia (GALT);
- Glutaric acidemia type I (GA I);
- Hemoglobin Sickle/Beta-thalassemia (Hb S/βTh);
- Hemoglobin Sickle/C disease (Hb S/C);
- Homocystinuria (HCY);
- Isovaleric acidemia (IVA);
- Long chain hydroxyacyl-CoA dehydrogenase deficiency (LCHAD);
- Maple syrup urine disease (MSUD);
- Medium-chain acyl-CoA dehydrogenase deficiency (MCAD);
- Methylmalonic acidemia (mutase deficiency) (MUT);
- Methylmalonic acidemia (Cbl A,B);
- Multiple carboxylase deficiency (MCD);
- Phenylketonuria (PKU);
- Propionic acidemia (PROP);
- Tyrosinemia type I (TYR I);
- Trifunctional protein deficiency (TFP);
- Very long-chain acyl-CoA dehydrogenase deficiency (VLCAD);
- 3-hydroxy 3-methyl glutaric aciduria (HMG), and
- 3-Methylcrotonyl-CoA carboxylase deficiency (3MCC).

Other diagnostic tests may include the urine for metabolic screen and/or the urine for organic acids.

**Microcephaly:** This is defined as a head circumference that is less than the 10th percentile for gestational age.

**Severe attachment disorder:** This refers to a mental and emotional condition occurring in the first two years of life that causes a child not to bond or to trust his primary caretaker.

**Failure to thrive:** This is defined as a failure to achieve expected growth for age. The causes are multiple with the most common being psycho-social.

**Autism Spectrum Disorder:** This refers to impairment in social interaction, impairment in communication skills, and a restricted and repetitive repertoire of activities and interests. Includes the diagnosis of Autism, Pervasive Developmental Disorder (PDD), Pervasive Developmental Disorder - Not Otherwise Specified (PDD-NOS), Asperger's Disorder, Rett's Syndrome, and Childhood Disintegrative Disorder

**Hemoglobinopathies:** Sickle cell anemia (Hb SS disease) (Hb SS).

**Cleft lip or palate**

## **“Other” Diagnosed Conditions With A High Probability Of Resulting in Developmental Delay**

The category of eligibility called “diagnosed physical or mental conditions with a high probability of resulting in developmental delay” is a limited one with some specific parameters. While IFSP teams are given discretion to identify “other” conditions under this category of eligibility, these “other” conditions must still meet the criteria that the condition has a high probability of resulting in developmental delay. Many chronic conditions and genetic disorders are more appropriately considered risk factors rather than diagnosed conditions that meet Virginia’s definition of eligibility. Some children with these risk factors will be eligible for Part C services because of a developmental delay or atypical development.

“Other” conditions are discussed below under several headings which describe how they actually should fit in the determination of Part C eligibility. However, please note that with any situation in which discretion is left to the IFSP team and only limited information is available to analyze, it is very difficult to state absolutes (e.g. this condition always goes here or never goes there). What follows is a summary related to where each of the listed “other” conditions would **usually** or **probably** fall:

<b>1. Conditions that are often listed as “Other” but actually belong in one of the conditions already listed in Virginia’s definition of eligibility:</b>	
<ul style="list-style-type: none"> <li>▲ Significant Central Nervous System Anomaly <ul style="list-style-type: none"> <li>▪ Agenesis of the Corpus Callosum</li> <li>▪ CMV</li> <li>▪ Dandy-Walker Syndrome</li> <li>▪ Delayed myelinization</li> <li>▪ Fetal Stroke</li> <li>▪ Hydrocephaly</li> <li>▪ Left Arachnoid Cyst</li> <li>▪ Lissencephaly</li> <li>▪ Mobius Syndrome</li> <li>▪ Significant Central Nervous System Anomaly</li> <li>▪ Sturge-Weber Syndrome</li> <li>▪ Symptomatic Congenital Infection</li> <li>▪ Toxoplasmosis</li> </ul> </li> <li>▲ Inborn Error of Metabolism <ul style="list-style-type: none"> <li>▪ Krabbe’s Disease</li> </ul> </li> <li>▲ Seizures/Significant Encephalopathy <ul style="list-style-type: none"> <li>▪ Infantile Spasms</li> <li>▪ Leucoencephalomalacia</li> </ul> </li> <li>▲ Visual Disabilities <ul style="list-style-type: none"> <li>▪ Albinism</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>▲ Chromosomal Abnormalities <ul style="list-style-type: none"> <li>▪ 18P Syndrome</li> <li>▪ 2-P Syndrome</li> <li>▪ Apert’s Syndrome</li> <li>▪ Chondrodysplasia</li> <li>▪ Crouzon’s Syndrome</li> <li>▪ Ehlers-Danlos Syndrome</li> <li>▪ Marden Walker Syndrome</li> <li>▪ Osteogenesis Imperfecta</li> <li>▪ Otopalatodigital Syndrome, Type II</li> <li>▪ Prader Willi Syndrome</li> <li>▪ Saethre-Chotzen Syndrome</li> <li>▪ Trisomy 2 with Mosaics</li> <li>▪ Tuberous Sclerosis</li> <li>▪ Turners Syndrome</li> <li>▪ Williams Syndrome</li> <li>▪ Wolf-Hirschorn Syndrome</li> </ul> </li> <li>▲ Brain or Spinal Cord Trauma <ul style="list-style-type: none"> <li>▪ Erb’s Palsy/Brachial Plexus Injury</li> <li>▪ Left parietal infarct with small subdural hygroma</li> </ul> </li> </ul>



**2. Conditions reported as “other” that are most likely listed correctly and qualify the child as eligible under Part C.**

- |  |  |
|--|--|
| ▲ Amniotic Band syndrome                     | ▲ Congenital myotonic dystrophy            |
| ▲ Arthrogryposis                             | ▲ Muscular dystrophy                       |
| ▲ Caudal Regression Syndrome                 | ▲ Poland Syndactyly                        |
| ▲ Congenital amputee                         | ▲ Spinal muscular atrophy/ Werdnig-Hoffman |
| ▲ Congenital muscle fiber disproportion type |  |

**3. “Other” conditions which actually fit under developmental delay or atypical development categories**

- ▲ Hypotonia -- atypical development
- ▲ Vocal Cord Paralysis -- speech/language development; atypical development

**4. “Other” conditions which are considered risk factors rather than diagnosed conditions with a high probability of resulting in developmental delay --** The following would be listed under risk factors on the child data form and would not, by themselves, make a child automatically eligible for Part C services in the absence of developmental delay or atypical development. Please note that some of the following may be symptoms of a qualifying diagnosed condition.

- |  |   |
|--|---|
| ▲ Bronchopulmonary dysplasia (BPD)       | ▲ Most tumors -- (e.g. cystic hygroma, lymphangioma, nephroblastoma, non-Hodgkins lymphoma)   |
| ▲ Burns                                  | ▲ Oculoauricular Vertebral Syndrome (may be eligible under congenital or acquired hearing loss if that is present)  |
| ▲ Chronic eczematoid rash                | ▲ One Lung  |
| ▲ Chronic Lung Disease                   | ▲ Periventricular leukomalacia (PVL)/periventricular cysts  |
| ▲ Congenital Diaphragmatic Hernia        | ▲ Pseudo Obstruction Syndrome   |
| ▲ Congenital Hip Dysplasia               | ▲ Reflux Disorder/Gastroesophageal reflux   |
| ▲ Diabetes Insipidus                     | ▲ Renal Disease, end stage  |
| ▲ DiGeorge Syndrome                      | ▲ Scoliosis   |
| ▲ Dwarfism/achondroplasia                | ▲ Shaken Baby Syndrome (could be a diagnosed disabling condition if it has resulted in a visual disability or brain or spinal cord trauma with abnormal neurologic exam at discharge) |
| ▲ Eating difficulties                    | ▲ Short Gut Syndrome  |
| ▲ Esophageal atresia                     | ▲ Subglottic Stenosis   |
| ▲ Heart Defect/Cardiac Condition         | ▲ Torticollis   |
| ▲ Hirshprung’s Disease                   | ▲ Total anomalous pulmonary venous return   |
| ▲ Hypert thyroidism                      | ▲ Tracheo-esophageal fistula  |
| ▲ Hypoplastic Lungs                      | ▲ VACTERL Association (Vertebral, Anal, Cardiac, Tracheoesophageal fistula, Renal/Radical, Limb Association)  |
| ▲ Hypoxia                                |   |
| ▲ Infantile botulism                     |   |
| ▲ IUGR (intrauterine growth retardation) |   |
| ▲ Laryngomalacia                         |   |
| ▲ Leukemia/Acute Lymphocytic Leukemia    |   |
| ▲ Liver Failure                          |   |
| ▲ Macrocephaly                           |   |
| ▲ Meconium Aspiration                    |   |
| ▲ Meningitis                             |   |

**5. “Other” conditions, where it just depends...**

- ⤴ Bihemispheric hematomas -- Could be a diagnosed disabling condition under Brain or Spinal Cord Trauma if there is abnormal neurologic exam at discharge or could be a risk factor under Brain/Spinal Cord Trauma if there is normal exam at discharge
- ⤴ Cranial Calcification -- this is generally a symptom of some other disease or trauma. Depending upon the cause, this could be listed as a diagnosed condition under brain/spinal cord trauma, symptomatic congenital infection, or other.
- ⤴ Midline cerebellar epidural hematoma -- same as above
- ⤴ Right Arm AVM (Arterial Veinous Malformation) with hypertrophy -- depends on the degree of hypertrophy

An excellent reference book regarding diagnoses, symptoms and outcomes (which may assist local teams in determining whether and how a medical condition fits within the diagnosed condition category) is available from W.B. Saunders Publishing: Smith's Recognizable Patterns of Human Malformation (5th edition, edited by Kenneth Jones, ISBN #0-7216-6115-7, the cost is about \$100).

## **Newborn Screen & Development: Facts about Genetic Diseases**

*(Developed in 2006 by Alexandra Iwashyna, Medical Intern)*

Effective March 2006, the Virginia Newborn Screening Services program, through the Virginia Department of Health, was expanded to include testing for 28 heritable disorders and genetic diseases. Infants under 6 months of age who are born in Virginia will be screened for the following disorders and diseases, which are identified through newborn dried blood-spot screening tests. Any infant whose parent or guardian objects on the grounds that the tests conflict with his religious practices or tenets will not be required to receive the newborn dried blood-spot screening tests. All of these disorders and conditions are considered diagnosed conditions with a high probability of resulting in developmental delay. Therefore, these infants will be eligible under Part C in Virginia.

### **1) Argininosuccinic acidemia (ASA)**

- a) Incidence: ~1 in 70,000
- b) Deficiency in an enzyme of the urea cycle leading to hyperammonemia
- c) May appear normal at birth
- d) Without treatment: symptoms of lethargy, vomiting, poor appetite, seizures, hypotonia and muscle weakness, breathing problems, coma and death
- e) Treatment: low protein diet and a special medical formula
- f) With early treatment (before symptoms occur): may develop normally, however, more often children have some mental retardation despite treatment
- g) Autosomal recessive

### **2) Beta-Ketothiolase deficiency ( $\beta$ KT)**

- a) Unknown incidence
- b) Deficiency mitochondrial acetoacetyl-CoA thiolase leading to build up in isoleucine
- c) May appear normal at birth (symptoms occur 6-24 mo)
- d) Without treatment: vomiting, dehydration, trouble breathing, extreme tiredness, occasionally convulsions, and can sometimes lead to coma or mental retardation
- e) NOTE: some with BKT never have symptoms
- f) Treatment: L-Carnitine & possibly low protein diet
- g) With early treatment (before symptoms): probable normal growth and intelligence, however, even with treatment, some children still have symptoms (metabolic crises) which can cause brain damage leading to learning disabilities, mental retardation or other problems (although after age 10 symptoms/crises are rare)
- h) Autosomal recessive

### **3) Carnitine uptake defect (CUD)**

- a) Unknown incidence
- b) Deficiency of carnitine uptake leads to in the tissues impaired ability to use fats to produce energy and ketone bodies.
- c) Without treatment: cardiomyopathy, muscle weakness, hypotonia and with repeat episodes brain damage leading to learning disabilities and mental retardation, heart failure, death.
- d) NOTE: some children never have symptoms

- e) Treatment: supplementation with carnitine & frequent feedings
- f) Treatment before symptoms or early: typical growth and development
- g) Treatment with continuing symptoms: repeat metabolic episodes can cause neurological damage over time leading to learning disabilities and mental retardation
- h) Autosomal recessive

#### **4) Citrullinemia (CIT)**

- a) Incidence: ~1 in 57,000
- b) Deficiency in an enzyme of the urea cycle leading to hyperammonemia
- c) Without treatment: symptoms of lethargy, vomiting, poor appetite, seizures, hypotonia and muscle weakness, breathing problems, cerebral edema, coma and death
- d) Treatment: Dietary restriction of protein & oral dosage of sodium phenylbutyrate and arginine
- e) With early treatment (before symptoms occur): may develop normally, however, some children may have some neurological impairment despite treatment
- f) Possibility of brain damage leading to learning disabilities and mental retardation correlates to severity of initial presentation and amount of recurrent episodes
- g) Recurrent episodes often occur with illnesses (e.g., common cold)
- h) Autosomal recessive

#### **5) Glutaric acidemia type I (GA I)**

- a) Incidence: ~1 in 30,000/40,000
- b) Deficiency in Glutaryl-coenzyme A dehydrogenase leading to excessive levels of amino acids and their intermediate breakdown products
- c) Without treatment: brain damage (particularly the basal ganglia which are helps control movement) leading to hypotonia, spasticity, involuntary movement disorder, delays in motor skills, speech problems and mental retardation
- d) Treatment: Prompt treatment of catabolic events and prevention of fasting during illnesses; diet modifications
- e) With treatment (even early treatment): up to 35% will have neurological insult and disability
- f) Autosomal recessive

#### **6) Isovaleric Acidemia**

- a) Incidence: ~1 in 100,000 live births
- b) Enzyme deficiency in isovaleryl-CoA dehydrogenase, involved in catabolism of Leu
- c) Without treatment: vomiting, lethargy, severe metabolic ketoacidosis progressing to coma and death (50% with the acute neonatal form will die during their first episode); some may have neurological damage though several make complete recoveries. The majority of patients are developmentally normal.
- d) Treatment: protein-restricted diet, special formula and carnitine supplementation
- e) With treatment: Most will have normal development (especially with early treatment)
- f) Autosomal recessive

#### **7) Long chain hydroxyacyl-CoA dehydrogenase deficiency (LCHAD)**

- a) Incidence: ~1 in 75,000 births

- b) Enzyme defect that prevents the body from breaking down fatty acids into an energy source
- c) Without treatment: lethargy, hypoglycemia, hypotonia, liver dysfunction, cardiomyopathy. Acute symptoms may be difficult to manage and resistant to therapeutic attempts (with high mortality) because the presentations may involve a lethal acute liver failure, a rapidly evolving cardiomyopathy, or hypoketotic hypoglycemic encephalopathy
- d) Treatment: avoid fasting, high carbohydrate and low fat diet supplemented with MCT oil
- e) With treatment: Normal development and learning abilities (if no damage from crises). Peripheral neuropathy, if present, may not improve and prevention of ophthalmological changes (pigmentary retinopathy\*) may not occur with treatment.
- f) Autosomal recessive

#### **8) Methylmalonic acidemia (mutase deficiency) (MUT)**

- a) Incidence: ~1 in 50,000-100,000
- b) Deficiency of the adenosylcobalamin-dependent enzyme methylmalonyl-CoA mutase leading to an inability to process certain proteins and fats properly
- c) Without treatment: lethargy, failure to thrive, recurrent vomiting, profound metabolic acidosis, respiratory distress, hypotonia, and later on renal failure. Complications of these episodes can include metabolic stroke, extrapyramidal signs, dystonia and brain damage leading to neurological damage.
- d) NOTE: Disease varies from fatal neonatal disease to asymptomatic & age of onset of symptoms can help prognosticate – those with later onset tend to have a more benign course.
- e) Treatment: Protein-restricted diet and special formula diet, OH-Cbl injections, carnitine supplementation, may need other medications
- f) With treatment: most serious of the methylmalonic acidemias up to 60% of patients die within the first year of life and of those that survive, 40% are developmentally impaired
- g) Autosomal recessive

#### **9) Methylmalonic acidemia (Cbl A,B)**

- a) Incidence: ~1 in 50,000-100,000
- b) Defect in intracellular cobalamin metabolism leading to an inability to process certain proteins and fats properly
- c) Without treatment: Episodic ketoacidosis with vomiting, lethargy and coma which can lead to death. Survivors can have developmental delays, growth retardation, spastic quadriplegia, dystonia and seizures, neutropenia, thrombocytopenia and osteoporosis
- d) Treatment: Protein-restricted diet, OH-Cbl injections, Vitamin B12
- e) With treatment: Children who respond to vitamin B12 treatment tend to do very well as long as treatment is continued. CblA has a far better prognosis than CblB. CblB has ~33% of patients with neurologic impairment.
- f) Autosomal recessive

#### **10) Multiple carboxylase deficiency (MCD)**

- a) Incidence: ~1 in 87,000

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\* Loss of night vision and peripheral vision in varying degrees

- b) Defect in cellular biotin transport or metabolism leading to impaired activity of three enzymes that are dependent on the vitamin biotin: propionyl CoA carboxylase, beta-methylcrotonyl CoA carboxylase, and pyruvate carboxylase
- c) Mimics biotinidase deficiency

#### **11) Propionic acidemia (PROP)**

- a) Incidence: ~1 in 100,000
- b) Deficiency of propionyl CoA carboxylase leading to acidosis and hyperammonia
- c) Without treatment: tachypnea, vomiting, lethargy, irritability, shock, coma, and death. Death is very likely if symptomatic in infancy. Repeated episodes leading to mental retardation
- d) Treatment: Diet modifications with special formulas without specific amino acids that make propionyl CoA
- e) With treatment: If had symptoms before treatment (or difficulty maintaining treatment), high probability of brain damage leading to developmental delay. Also optic nerve atrophy may occur.
- f) Autosomal Recessive

#### **12) Tyrosinemia type I (TYR I)**

- a) Incidence: ~1 in 100,000
- b) Deficient enzyme in catabolism of tyrosine
- c) Without treatment: Symptom onset as early as 2-6 wks with FTT, chronic liver disease (liver disease can start prenatally)
- d) Treatment: special formula restricted in specific amino acids, the medication Orfadin, and typically liver transplant
- e) With treatment: Risks with liver transplant including infections or rejection
- f) Autosomal recessive

#### **13) Trifunctional protein deficiency (TFP)**

- a) Unknown incidence
- b) See LCHAD (mimics disease)
- c) Autosomal recessive

#### **14) Very long-chain acyl-CoA dehydrogenase deficiency (VLCAD)**

- a) Unknown incidence
- b) Defect in very long-chain acyl-CoA dehydrogenase leading to problems breaking down fats to energy
- c) Without treatment: variable, from recurrent episodes of hypoglycemia to cardiomyopathy and liver problems and can progress to coma, cardiac arrest, brain damage, or even death (especially in children who are not eating well)
- d) Treatment: eating frequently and avoiding fasting, and sometimes medication (carnitine)
- e) With treatment: not much data but it looks like resolution of cardiomyopathy and normal development and learning abilities especially for later-onset disease
- f) Autosomal Recessive

#### **15) 3-hydroxy 3-methyl glutaric aciduria (HMG)**

- a) Unknown incidence
- b) A defect in HMG lyase leading to problems breaking down an amino acid (leucine)

- c) Without treatment: vomiting, dehydration, extreme tiredness, seizures, hypoglycemia, metabolic acidosis, and coma
- d) Treatment: a special diet (low leucine), including medical foods and formula, possible medications (carnitine)
- e) With treatment: good chance to have typical growth and development. However, even with treatment, some children still have repeated bouts of hypoglycemia or metabolic crises which may cause brain damage leading to learning problems or mental retardation
- f) Autosomal recessive

**16) 3-Methylcrotonyl-CoA carboxylase deficiency (3MCC)**

- a) Rare
- b) A deficiency in 3-methylcrotonyl CoA carboxylase (3MCC) is leading to problems breaking down an amino acid (leucine)
- c) Without treatment: vomiting, dehydration, extreme tiredness, seizures, hypoglycemia, metabolic acidosis, and coma
- d) Treatment: a special diet (low leucine), including medical foods and formula, possible medications (carnitine)
- e) With treatment: good chance to have typical growth and development. However, even with treatment, some children still have repeated bouts of metabolic crisis which may cause brain damage leading to learning problems or mental retardation
- f) Autosomal recessive

## Chapter 6: Assessment for Service Planning

Assessment for service planning includes several steps in the early intervention process. The required activities will occur through a combination of phone contact and/or a visit(s) with the family. The number of visits and phone calls needed to accomplish these activities will be individualized to meet each family's need for information, time to consider options and other family scheduling preferences. This step in the early intervention process includes the identification of the resources, priorities and concerns of the family through a family-directed family assessment. A multidisciplinary team reviews existing medical and developmental information and conducts observation and assessment of the eligible child to determine the child's strengths and needs in all areas of development and to assist the IFSP team in identifying the early intervention supports and services necessary to address the child's unique needs. An assessment tool(s) will be used at this point as an objective anchor for the comprehensive assessment of the child's functional skills in comparison to same age peers for determination of the child's entry status on the OSEP child indicators. Planning and preparation for the IFSP meeting begin and family cost share paperwork is completed.

### Completing the Assessment for Service Planning

General:

1. Assessment can occur in a variety of ways and at several points in the early intervention process. This chapter describes the practices associated with the assessment for service planning that occurs after the child's initial eligibility is determined and before the meeting to develop the initial IFSP. The following is a list of all of the different types and purposes of assessment that occur throughout the early intervention process:
  - a. Assessment for eligibility – Targeted assessment designed to provide the eligibility determination team with further information about a specific area(s) of development when existing information is not sufficient to determine eligibility. The eligibility determination team identifies the area(s) of development that need to be assessed, and the purpose of this assessment is to determine whether the child meets the eligibility criteria for Part C. An assessment tool is not required.
  - b. Assessment for service planning – Comprehensive assessment designed to:
    - Determine the child's strengths and needs in all areas of development;
    - Identify the family's priorities, resources and concerns;
    - Assist the IFSP team in identifying the early intervention supports and services necessary to address the child's unique needs; and
    - Assess the child's functional skills in comparison to same-age peers for determination of entry ratings for the three child indicators (positive social relationships, acquiring and using knowledge and skills, and taking appropriate action to meet needs).Use of a comprehensive assessment tool is required.
  - c. Ongoing assessment – Assessment based on observation of the child's functioning and skills across all developmental domains that occurs as a routine part of service delivery. The purpose of ongoing assessment is to give the provider and the IFSP team, including the family, information on



the child's progress on the outcomes and short-term goals being addressed by the current activities and to assist in identify any emerging concerns in other areas of development. No assessment tool is required; but, when needed, the service provider may use an assessment tool as a reference point, especially for areas of development outside his/her area of expertise.

- d. Exit assessment – An assessment of the child's functional skills compared to same-age peers using information from parent report, an assessment instrument, observation and other sources to determine the child's status (rating) for each of the child indicators. A formal assessment is not required, though documentation of the child's abilities using an assessment tool (such as the HELP, ELAP, etc.) is required.

#### Service Coordinator Responsibilities:

1. When notifying the family that their child is eligible, share information about the process for child and family assessment and IFSP planning. Explain the family's role in these steps of the early intervention process, the other people who will be involved, and the service coordinator's role in coordinating the activities and supporting the family's active participation. Discuss the notice and consent requirements related to assessment for service planning and determine with the family whether they would like to proceed to assessment or would prefer more time to consider their options. This may be accomplished by phone contact(s) or a visit with the family, depending on the needs and preferences of the family.
2. Provide a copy and explanation of the procedural safeguards forms associated with assessment for service planning:
  - a. Provide a copy and explanation of the *Notice and Consent for Assessment* form and the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System* prior to conducting any assessment activities. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined. The form and rights document may be mailed to the family after discussion by phone or may be handled during a visit with the family depending on family preferences. Depending on the child and family circumstances, this paperwork may have been completed during intake.
    - Individual families and participating family members must be informed before any formal or informal process to identify family resources, priorities and concerns begins, that participation in such family assessment activities is strictly voluntary on the part of the family, that the process shall be family directed, and that a family's decision not to participate in the assessment of the family's resources, priorities and concerns will not affect the child's eligibility for early intervention supports and services.
    - Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.

- b. Ensure the following occur if the family declines to proceed to assessment for service planning:
  - Provide a copy and explanation of the *Declining Early Intervention Services* form and the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System* related to declining services.
    1. Using the bottom half of the *Declining Early Intervention Services* form, the family is asked to mark the second line (that they understand that an IFSP can be developed for their child/family and that they do not choose to have their child receive an IFSP). Explain to the family how they can contact the local Infant & Toddler Connection system in the future using the phone number provided at the bottom of the form if they have concerns about their child's development.
    2. In explaining the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
  - If the child is close to being age eligible for early childhood special education services through the local school division (under Part B), explain how to access Part B services through the local school system.
  - Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.
  - Obtain parent consent to communicate with the primary care physician and primary referral source, if not already provided.
  - Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.
  - Document in ITOTS, within 10 business days of the family declining to proceed, that the child was evaluated to determine eligibility and that either the child was eligible/declined services or was eligible/chose other services.
3. Support the family in assessing their resources, priorities and concerns. This includes identifying natural environments and gathering other family input for IFSP development. Explain that this information helps in service planning since the focus of supports and services is on increasing the child's participation in family and community activities that are important to the family.
  - a. The method of obtaining information from the family must be directed by the family, meaning that the family decides what information they want to share and how they want to share it. Methods may include, but are not limited to, a conversation, a checklist or other written options and address

- daily family routines and activities and the family's perceptions of their child's abilities and needs in the context of daily activities. No one method is recommended for all families.
- b. Each family should be offered multiple and continuing opportunities to identify their own resources, priorities and concerns in those areas of family life that the family feels are relevant to their ability to enhance the child's development.
  - c. The information gathered from the family during intake to assist in determining eligibility may be re-visited or expanded upon as part of the family assessment.
4. Coordinate the multidisciplinary assessment of the child for service planning. The assessment for service planning includes reviewing available pertinent records that relate to the child's current health status and medical history and conducting personal observation and assessment of the child in order to identify the child's unique strengths and needs, including an identification of the child's level of functioning in each area of development (cognitive development; physical development, including vision and hearing; communication development; social or emotional development; and adaptive development) based on objective criteria, which must include informed clinical opinion. The assessment information is also used to determine entry ratings for the three child indicators (positive social relationships, acquiring and using knowledge and skills, and taking appropriate action to meet needs). The determination of entry ratings on the three indicators may occur at the assessment for service planning or the IFSP meeting if those two activities occur on different days. See #5, below, for more information on determining entry ratings on the three child indicators.
- a. (Optional) Use the *Confirmation of Scheduled Meetings/Activities* form to provide the family with a written reminder of the date, time, place and participants for the assessment for service planning.
  - b. Obtain physician referral/authorization, if needed, for assessment.
    - o In order to receive reimbursement at the full TRICARE rate for assessment by a specialty provider (OT, PT or SLP), there must be a referral from the primary care manager (PCM) prior to the assessment. With careful planning, this step need not significantly impact the 45-day timeline since the PCM must offer an appointment within one week of the family's request to be seen. The single point of entry or the service coordinator must determine at the time of referral or in the first contact with the family whether the family is a TRICARE Prime beneficiary so the appointment with the PCM and referral for specialty provider assessment can be obtained as quickly as possible. If the family chooses to delay the appointment with the PCM due to a family scheduling preference or child/family illness, then any delay in the 45-day timeline would be due to those family reasons. If the child is assessed by a specialty provider without a prior referral from the PCM, then the assessment would be covered under the point of service option and is reimbursed under TRICARE at 50% of the TRICARE rate. The beneficiary is responsible for the other 50%. Since this is an assessment and Part C regulations require that assessments must be provided at no cost to the family, Part C funds would have to be used to cover the beneficiary's share.

- Physician referral is needed for a physical therapy assessment regardless of the reimbursement source, except as allowed under PT regulations (see [http://www.dhp.virginia.gov/PhysicalTherapy/physther\\_laws\\_regs.htm](http://www.dhp.virginia.gov/PhysicalTherapy/physther_laws_regs.htm), § 54.1-3482 B)
- c. Ensure that a comprehensive assessment tool is used as the foundation of the child assessment. The reason for using a foundation tool is not to generate age levels but to serve as an anchor for the assessment and to provide a standard measure to be used in combination with other assessment sources for determining the child's functional status on the OSEP child indicators in relation to same-age peers. Discipline-specific assessment tools may be used in addition to the comprehensive assessment, if needed for an individual child.
- d. Ensure two or more different disciplines are involved in the assessment for service planning. It is possible that one or more disciplines were involved in assessment activities prior to or since referral that may be used for service planning. These assessors count towards the requirement for 2 disciplines to participate as long as there is a written report from that discipline.
  - Information gathered by a qualified provider as part of the intake (such as screening and observation performed by an Occupational Therapist) can be used to meet the requirement for one of the disciplines.
  - Developmental information provided by a physician or a provider who is from a discipline listed in Table A at the end of Chapter 12 but who practices outside the local Part C system can be used to meet the requirement for one of the disciplines if the physician or outside provider includes information that can be used for service planning. This information may include, but is not limited to, results from an assessment tool, observations of child development, and information about current or projected impact of the child's health on his/her development. The local system determines whether the information provided by the physician or outside provider can be used for service planning (e.g., whether it is helpful in identifying outcomes, short-term goals, necessary supports and services, and/or treatment modalities).
- e. Participate in any assessment activities that occur after referral, supporting the family as an active participant in the assessment.
- 5. Facilitate determination of entry ratings for the three child indicators (positive social relationships, acquiring and using knowledge and skills, and taking appropriate action to meet needs) for all eligible children new to early intervention who are 30 months or younger at the time of the initial IFSP. This includes children who have received early intervention from other states, but who are new to early intervention in Virginia. The entry ratings recorded in ITOTS follow the child. A child who moves within Virginia from one early intervention system to another will already have entry assessment data, and the new local system does not need to do a new entry-level assessment. If a child is discharged from the Part C system and returns within 6 months of leaving the system, then the initial child indicator ratings continue to be used as the entry ratings. If the child is out of the system for more than six months but returns to the system when he/she is still 30 months old or younger then new entry indicator ratings are completed.

- a. Entry assessment information is derived from multiple sources:
    - Results from developmental instruments and observation;
    - The family, including information about the child's performance in relation to the three indicators across situations and settings and with different people;
    - Any other source (e.g., child care provider, medical records, etc.)
  - b. Considering the information above and functional skills of same-aged peers, the team determines the appropriate rating from 1-7 for each of the indicators. The Decision Trees and other documents available at <http://www.infantva.org/ovw-DeterminationChildProgress.htm> can be used to guide the process.
  - c. The team completes the front page of the Child Indicator Summary Form (CISF). If documentation on the IFSP and in the child's record is not sufficient to support the rating decisions, then supporting documentation must be provided on the back of the CISF. Documentation must include the sources of information (instrument, observation, parent report, etc.) and the information from those sources about the child's functional skills across settings, situations and people. The completed CISF is maintained in the child's early intervention record. If the CISF or the information required on the CISF is completed and maintained electronically, then it is not necessary to also complete a hard copy of the form as long as the information on the CISF can be produced in full from the electronic record.
6. Enter into ITOTS any additional reasons for eligibility if additional reasons were identified during the assessment for service planning than were identified at the time of eligibility determination. These additional reasons for eligibility should also be documented in a contact note and/or the Team Assessment Narrative on page 3 of the IFSP.
  7. Complete the following steps in those rare instances where the child was found eligible by the multidisciplinary team based on a review of available documentation (including results of any screenings completed, medical information, parent report, formal/informal observation and written assessment reports if available) but the child has made progress since the eligibility determination and is no longer eligible based on the information gathered during the assessment for service planning.
    - a. Congratulate the family on the good news that their child's development now appears to be closer to or at age level or more typical than it first appeared.
    - b. Provide the parents with a copy and explanation of the *Parental Prior Notice* form (indicating "Your child is not eligible for Infant & Toddler Connection of Virginia") and the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*. On the *Parental Prior Notice* form, identify the information used to make the determination that the child is not eligible. In explaining the *Notice of Child and Family Rights and Safeguards*, review and explain the complaint procedures. Even if the family has already received a copy of the *Notice of Child and Family Rights and Safeguards* document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A

- contact note must be used to document that another copy of the document was offered and that the family declined.
- c. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.
8. Document any and all circumstances that result in required assessments not being completed within the required timelines.

**Responsibilities of Other Early Intervention Service Providers:**

1. Focus on gathering information through the assessment that is important for the IFSP team to use in service planning (e.g., functional skills, developmental strengths, areas of concern). The providers conducting the assessment are not recommending specific services, only providing information (e.g. functional skills the child has, areas of concern, skills not observed, etc.) for the IFSP team to use in identifying desired outcomes and the necessary supports and services.
2. Review any assessment information less than six (6) months old to determine if it is appropriate for consideration in service planning in order to prevent children and families from undergoing unnecessary assessment and duplication of existing assessment information. However, given the rapid changes in growth and development in infancy, it is important that all information used in service planning accurately reflects a child's current status.
3. Check in with the family during the assessment to determine whether the skills and behaviors observed are representative of what the family sees at other times and in other places or situations.
4. Participate in the determination of the child's status on the three OSEP indicators.
5. Document the assessment results, including the child's level in all developmental areas and the child's skills and abilities that support the child status rating for each of the three OSEP indicators. Individuals participating in the assessment for service planning may document their findings directly in the "Team Assessment Narrative" section of the IFSP or in a separate written report that the team then reviews and integrates into the "Team Assessment Narrative."
6. Provide assessment results to the service coordinator prior to the IFSP meeting, unless clearly not feasible to do so, so that this information is available to all IFSP team members.
7. Limit the use of jargon and acronyms and explain words or concepts that may be unfamiliar to the family.

**Planning for the IFSP Meeting**

**Service Coordinator Responsibilities:**

1. Review family cost share practices with the family. These should have been introduced during referral and intake. The service coordinator is also responsible for ensuring the *Family Cost Share Agreement* form is completed in accordance with the procedures specified in Chapter 11. Since the financial intake includes sharing personal financial information, care must be taken when combining eligibility determination and/or assessment for service planning and/or IFSP development to ensure the family has an opportunity for privacy during the financial intake.
  - a. If there is documentation from the physician of a qualifying diagnosed condition prior to the eligibility determination and the family wishes to combine the eligibility determination with the assessment for service

- planning, and potentially the IFSP meeting, then financial intake can be conducted prior to the combined activities.
- b. Otherwise, when eligibility determination and assessment for service planning are combined, then the financial intake should occur between assessment for service planning and the IFSP meeting. If the family wants the IFSP meeting also to occur on the same date, then the service coordinator needs to be sure the family understands (before consenting to this arrangement) that the financial intake will need to occur that day as well, prior to the IFSP meeting. The family should be made aware that if they wish to discuss these matters privately and if these activities are happening at the family's home, then there will need to be a separate place where the service coordinator and family can go to discuss the financial matters. Provider participants should also be made aware of the need to conduct financial intake during these combined activities since it impacts their time and availability for other activities and services.
2. Identify an ongoing service coordinator.
  3. Work with the family to identify the composition of the IFSP team. Required team members include the following:
    - a. The parent(s) of the child;
    - b. Other family members, as requested by the parent, if feasible;
    - c. An advocate or person outside the family if requested by the parent;
    - d. The service coordinator who has been working with the family since referral and/or the ongoing service coordinator;
    - e. A person or persons involved in eligibility determination and/or assessments; and
    - f. As appropriate, individuals who may be providing supports and services to the child and family.
  4. Determine with the family whether a foreign language or sign language interpreter will be needed for the IFSP meeting. If so, identify an interpreter in accordance with the following:
    - a. A professional foreign language interpreter is not required. An IFSP team member may be able to interpret or there may be an extended family member, neighbor, clergyman, or other family friend who would be willing and able to interpret (if the family agreed). The local Infant & Toddler Connection system may wish to collaborate with the local school system(s) in finding foreign language interpreters since Part B has the same requirements related to native language. A neighboring local system also may be able to assist if the service coordinator is having difficulty locating a foreign language interpreter. Document in a contact note(s) all efforts to locate an interpreter.
    - b. When sign language interpreters are needed during IFSP meetings in order to meet the requirement related to family's mode of communication, these interpreters must meet professional licensure requirements. To locate qualified sign language interpreters, contact the Virginia Department for the Deaf and Hard of Hearing (1-800-552-7917) or access their website, [www.vddhh.org](http://www.vddhh.org), for a directory of qualified interpreters. If a licensed sign language interpreter is not available in the area served by the local system, then document efforts to locate a licensed sign language interpreter and use a family member, family friend or other informal resource to provide the needed interpreting.
  5. Plan and schedule the IFSP meeting.

- a. Provide the family with a copy and explanation of the *Parental Prior Notice* form (with check marks by “Your child is eligible for Infant & Toddler Connection of Virginia” and “A meeting to develop the initial IFSP is needed”), *Confirmation of the Individualized Family Service Plan (IFSP) Schedule* form, and *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*. Emphasize those safeguards applicable to IFSP development. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
- b. Schedule the IFSP meeting at a time convenient for team members with preference being given to times that are best for the family. While development of the IFSP is a separate step in the process, the IFSP meeting may occur on the same day as the assessment for service planning if that is the family’s preference. Talk with families about this when planning and scheduling the assessment for service planning. Families may need time to review and consider the assessment information, do research or ask questions in understanding and preparing for the IFSP development process. Parents may want to talk with other family members or individuals who offer guidance and support to them before participating in the IFSP meeting. A decision to combine the assessment and IFSP meeting activities on the same date must be made by a fully informed family and cannot be required by the local system.

Talking with Families about Conducting the Assessment for Service Planning and the IFSP Meeting on the Same Day:

Consider using the following language in explaining the advantages and disadvantages of completing the assessment for service planning and the IFSP meeting on the same day: “Some families prefer to move straight from the assessment for service planning into the IFSP meeting. This can mean fewer visits/meetings, getting started sooner on services and has the advantage that the assessment information is fresh in your mind. On the other hand, some families prefer to wait and hold the IFSP meeting on a different date. Combining it all on one day can be a lot ... it can take a couple of hours. Families may find it helpful to wait because they want time to review and consider the assessment information, do research or ask questions in understanding and preparing for the IFSP development process. You may want to talk with other family members or individuals who offer guidance and support to you before participating in the IFSP meeting. You should feel free to decide based on what you think is best for your family. ”



- c. Arrange IFSP meetings in the setting and language that facilitates a family's ability to participate.
- d. Notify all participants in writing of the date, time and location for the IFSP meeting.
  - Parents must be notified using the *Confirmation of Individualized Family Service Plan (IFSP) Schedule* form.
  - Other team members may be notified using that same form or through other written means (e.g., email).
  - Documentation must be maintained in the child's early intervention record that shows that the family and other team members were notified in writing in advance of the IFSP meeting.

If the family thinks they want to do the assessment for service planning and IFSP meeting at the same time, then notification of the IFSP meeting is sent out ahead of the assessment for service planning to ensure all participants are aware of the plans. Even though the family may have planned to do the IFSP on the same day as the assessment for service planning, the family may change their mind after the assessment is completed and decide that they prefer to delay the IFSP meeting until another day.

- e. Ensure that IFSP team members who are not able to meet at times convenient for the family are given other options for IFSP participation, such as telephone consultations or providing written information.
- f. Assist the family in preparing for the IFSP meeting by reviewing a blank copy of the statewide IFSP form with the family, explaining the different sections and discussing the kind of information included and the role the family can play in providing that information. Offer to leave a blank form or select pages of the blank form with the family, suggesting that they might want to make notes of their input and questions in each section of the blank form and bring that to the IFSP meeting as a reminder for the family during the meeting. The level of support that each family will want and need in preparing for the IFSP meeting will vary and preparation should be individualized for each family.
- g. Ensure the following occur if the family declines to proceed to IFSP development:
  - Ensure that the family's signature is obtained on the *Declining Early Intervention Services* form and that the family receives further explanation of sections of the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System* related to declining services.
    - 1) Using the bottom half of the *Declining Early Intervention Services* form, the family is asked to mark the second line (that they understand that an IFSP can be developed for their child/family and that they do not choose to have their child receive an IFSP).
    - 2) Explain to the family how they can contact the local Infant & Toddler Connection system in the future using the phone number provided at the bottom of the form if they have concerns about their child's development.
    - 3) In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures.

Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.

- If the child is close to being age eligible for early childhood special education services through the local school division (under Part B), explain how to access Part B services through the local school system.
- Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.
- Obtain parent consent to communicate with the primary care physician and primary referral source, if not already provided.
- Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.
- Document in ITOTS, within 10 business days of the family declining to proceed, that eligibility determination was completed and the child was either eligible/declined services or eligible/chose other services

#### ITOTS Data Entry – Assessment

1. If the family declines to proceed in the early intervention process, the local system manager ensures that the following data is entered into ITOTS within 10 business days of the family declining to proceed:
  - a. Eligibility determination Completed? Yes
  - b. Date of eligibility determination
  - c. Result of eligibility determination: Eligible/Declined Services or Eligible/Chose Other Services
2. If additional reasons for eligibility were identified during the assessment for service planning than were identified at the time of eligibility determination, enter those additional reasons.
3. Otherwise, no further data can be entered into ITOTS until the IFSP is signed or the child is discharged (e.g., lost to contact or family declines to proceed).

[Complete ITOTS instructions are available at

<http://www.infantva.org/documents/forms/INST1117eR.pdf>]

#### Local Monitoring and Supervision Associated with Assessment for Service Planning

The local system manager provides the supervision and monitoring necessary to ensure the following:

1. Procedural safeguards forms are used and explained appropriately.
2. Assessment for service planning occurs in a timely manner so that the initial IFSP meeting can be held within the 45-day timeline. Any circumstances that result in a delay in the assessment for service planning are fully documented in the child's record.
3. A comprehensive assessment tool is used as the foundation of the child assessment.

4. Assessment documentation is sufficient to support child indicator rating decisions.
5. Child indicator ratings appear to be appropriate based on the documentation of child functioning.
6. Efforts to secure foreign language and sign language interpreters to assist the family's active participation in the assessment for service planning are documented.

## Chapter 7: IFSP Development

The Individualized Family Service Plan (IFSP) is developed through a family-centered team planning process in which the family is supported to participate as an equal team member. The child's family helps the IFSP team and service providers understand the child's and family's daily routines and activities. The providers then assist the family in recognizing and utilizing existing learning opportunities and creating new ones that will help the child reach the desired outcomes. The resulting IFSP reflects the family's priorities, resources, and concerns; the child's functional strengths and needs; the outcomes the family would like to see for their child and family; and the supports and services necessary to achieve those outcomes.

### The Initial IFSP Meeting

#### Service Coordinator Responsibilities:

1. Conduct, in person, the initial IFSP meeting within the 45-calendar day timeline. If more than one meeting is needed to complete the IFSP, the first meeting must be within the 45-day timeline.
2. Ensure that the IFSP meeting includes determination of entry ratings for the three child indicators (positive social relationships, acquiring and using knowledge and skills, and taking appropriate action to meet needs) for all eligible children new to early intervention who are 30 months or younger at the time of the initial IFSP, unless this was completed during the assessment for service planning. Details about the determination of entry ratings are provided in the "Completing the Assessment for Service Planning" section of Chapter 6.
3. Ensure that the meeting is conducted in the family's native language or other mode of communication unless clearly not feasible to do so.
4. Ensure that the IFSP team uses both information from the family regarding their priorities and results of the child assessment, including a review of pertinent records less than six (6) months old from the primary care physician and other sources related to the child's current health status, physical development, medical history, and other information regarding the child's development in determining which IFSP services and informal/formal supports and resources are needed.
5. Inform the family that inclusion in the IFSP of information from a family-directed family assessment related to enhancing the development of the child is voluntary and refusal to include information from such an assessment in the IFSP in no way jeopardizes the supports and services provided as part of the IFSP.
6. Encourage and support the family to be a full and equal partner on the IFSP team. The service coordinator may support the family's participation in the IFSP meeting in a variety of ways, including, but not limited to, the following: by ensuring the family is able to lead discussions within the meeting (e.g., family resources, priorities and concerns) as desired by the family, raising issues the family has identified as important, ensuring the family is getting the chance to speak and share opinions, explaining any jargon, etc.
7. Establish and support a team approach to service planning that recognizes and respects the expertise of all team members, including the family.
8. Build team consensus on IFSP outcomes and the supports and services necessary to achieve the outcomes.
9. Begin a discussion with the family about transition. Depending on the child's age at the initial IFSP as well as family priorities and preferences, transition planning at the initial IFSP meeting will range from sharing basic and general information

about what transition means and when it may occur to beginning more detailed planning of specific transition steps and services.

**Responsibilities of Other Early Intervention Service Providers:**

1. Participate in the IFSP meeting. This applies to service providers who were part of the eligibility determination team and/or conducted assessment for service planning. Providers who may be providing supports and services also participate in the initial IFSP meeting, as appropriate. Service providers who are not able to participate in the meeting in person may participate through other options, such as telephone consultations or providing written information. When participating by providing written information, service providers include assessment information related to service planning as well as recommendations related to intervention strategies for the rest of the IFSP team to consider when developing outcomes, strategies and necessary supports and services.
2. Limit the use of jargon and acronyms and explain words or concepts that may be unfamiliar to the family.
3. Assist the family in developing desired outcomes by starting with the activity settings in which the family participates and identifies as important and/or activity settings the family would like to pursue.
4. When developing strategies to address the IFSP outcomes, focus on interest-based learning opportunities that occur throughout the child's and family's daily routines and activities.
5. Consider multiple factors when working as a team, with the family, to identify the supports and services necessary to meet the IFSP outcomes. These factors include the expertise needed to support the family in addressing the IFSP outcomes, the abilities and interests of the child and family, needs expressed by the family, and family and community resources. IFSP team members assist the family in examining the expertise and experience of individual providers across disciplines to determine which service can best meet the IFSP outcome(s).
6. Consider whether one primary provider can address all of the outcomes, with support from other team members. This is often the case since there is significant overlap in training and scope of practice across disciplines. Identify on the IFSP not only the primary service provider(s) but also the role of other team members in supporting the family and other service providers. These other team members may participate in joint early intervention visits with the primary provider(s) to the child and family and/or provide consultation to the primary provider(s) by suggesting strategies and techniques to enhance progress toward outcomes.
7. Consider the following kinds of questions in determining the frequency and intensity of supports and services needed to meet the IFSP outcomes:
  - a. Is the relationship between the child/family/caregiver and the provider new (e.g., because they have just begun this service or because there has been a change in providers) or well-established?
  - b. Will the strategies used to address the outcomes need to be modified frequently or will the same strategies be used for a long period of time?
  - c. Is attainment of an outcome(s) especially urgent and able to be resolved quickly with intensive intervention (e.g., new referral of a child with non-organic failure-to-thrive, which needs quick resolution; or a child's behavior is preventing the family from finding a child care provider who will accept the child)?

- d. Are there a large number and/or wide variety of strategies involved in addressing the IFSP outcomes or are there relatively few or more similar strategies?
  - e. Is the child progressing at the expected rate in meeting identified outcomes?
  - f. What are the family's/caregiver's learning needs in relation to the child's developmental needs and the IFSP outcomes?
  - g. Do the outcomes require a high level of specialized skill to address or are they more easily implemented with minimal guidance and instruction?
  - h. Are the outcomes or strategies new for the child and family?
  - i. Will the service provider(s) be working with only the family or with other caregivers as well in addressing IFSP outcomes?
  - j. Is the parent's understanding of and/or his or her ability to assist with implementing suggested activities affected by his or her own cognitive or emotional issues?
  - k. Does the child need intensive, one-on-one support to participate in his/her environment? (In this case, there also may be a need for an increase in support to the family in addressing the IFSP outcomes.)
8. Consider the information in the box on the next page when discussing a child's need for an assistive technology device.
  9. Participate in the identification of a location(s) for supports and services that is based on the activities that are being addressed (as identified in the IFSP outcomes).

When considering the purchase of an Assistive Technology Device:

- Determine whether the assistive technology device is a medical device or a developmental device. If a physician must deliver the device, then it is considered a medical device and is not the responsibility of the Infant & Toddler Connection of Virginia. If providers other than a physician (e.g., nurse, physical therapist, occupational therapist, audiologist, speech-language pathologist, etc.) can deliver the device then it is considered developmental and can be considered a Part C service. Medical devices include, but are not limited to, suction machines, glucose monitors, feeding pumps, apnea monitors, enteral and parental solutions and supplies, nebulizers and ventilators.
- First consider or try simple, low- or non-tech modifications or solutions and then build up to mid-tech and to high-tech modifications or devices as needed.
- Whenever possible, use loaner equipment for higher-tech devices\* before purchasing a specific device for an individual child. This allows the family and provider to determine how well the device meets the needs of this individual child and his/her family before spending money on the purchase of the device.
- Assist the family in understanding the implications of the funding source for an assistive technology device:
  - If purchased with the family's health insurance (public or private), the assistive technology device belongs to the family and they may keep it when they leave the Infant & Toddler Connection of Virginia.
  - If federal or state Part C funds are used to pay for more than 50% of an assistive technology device and the device is valued at \$5,000 or more, then the assistive technology device belongs to the local Infant & Toddler Connection system and must be treated as follows when the child leaves the system:
    - The assistive technology device is returned to the local Infant & Toddler Connection system, re-inventoried and used for other children on a loaner or trial basis.
    - If the child is transitioning to preschool special education services under Part B through the local school division, then the local school system may receive the assistive technology device and utilize it as long as the child needs it. Once the child no longer needs the device, it is returned to the local Infant & Toddler Connection system.
    - If the child is transitioning to a program other than preschool special education services under Part B, then the receiving program may purchase the assistive technology device with appropriate depreciation consideration.
  - Assistive technology devices that are expendable, personal use items (e.g., bath forms, ear molds) are for the personal use of the specific child and are not reclaimed.
- Ensure Part C funds are used as the payor of last resort in purchasing an assistive technology device and document efforts to access other funding sources, including, but not limited to, the following:
  - Equipment loan organizations, if appropriate
  - Equipment donation facilities
  - Local civic and community organizations
  - Public or private health insurance
  - Family feesEfforts to access other funding sources prior to the use of Part C funds must be documented in contact notes or on a payor source checklist or similar form.

\* The Virginia Hearing Aid Loan Bank is open to children under age 18 years of age whose hearing loss is confirmed by an audiologist. The bank loans hearing aids and FM systems for up to six months. The initial loan period can be extended for an additional 6 months in certain circumstances. To qualify, families must be residents of Virginia and be in the process of securing permanent hearing aids through insurance or other means. Parents can apply for hearing aids and FM systems by completing an application form. For more information about this program, call Lisa Powley at the Blue Ridge Care Connection for Children at (434) 924-0222 or 1-866-596-9367. See also <http://www.vahealth.org/hearing/valoanerbank.htm>.

#### Completing the IFSP form

##### Service Coordinator Responsibilities:

1. Ensure the development of an IFSP for each eligible child, with parent consent. The IFSP is developed using the statewide IFSP form and in accordance with the instructions detailed at the end of this chapter.
2. Explain the contents of the IFSP to the parent(s) and obtain written consent from the parent(s) by signature on the IFSP form prior to the provision of early intervention supports and services described in the IFSP. Ensure the IFSP is translated orally or in writing into the family's native language or other mode of communication unless clearly not feasible to do so. The IFSP must be complete (with the exception of the Addendum page) before asking the family to sign.
3. Retain a signed copy of the IFSP and provide a copy to the family and to all service providers who participated in assessment or development of the IFSP or will be implementing the IFSP. The parental consent statement that the family signs on the IFSP gives consent for the IFSP to be shared with these providers.
4. Send a copy of the IFSP to the child's primary care physician, with parent consent. Consent to send a copy of the IFSP to the physician is not covered by the consent statement on the IFSP and requires a separate release of information form.
5. Obtain physician (or physician assistant or nurse practitioner) signature on one of the following to document medical necessity for services if the child is covered by public (Medicaid or TRICARE) or private health insurance and will receive services that can be reimbursed under that insurance plan.
  - a. The IFSP; or
  - b. A separate letter referencing the IFSP that is sent with the IFSP; or
  - c. The IFSP Summary Letter.

This documentation also serves as the physician order for the medically necessary services listed on the IFSP. The box on the next page provides additional information about the requirement for physician signature on the IFSP.



Specific Requirements Related to Physician Signature:

- The physician signature is required for the initial IFSP, annual IFSP and anytime services change (as determined through the IFSP Review process).
- The physician signature must be dated by the physician.
- The physician certification of the IFSP is considered a part of the IFSP and must be attached to the IFSP.
- The IFSP must be certified as a whole (i.e. it is not acceptable to have more than one individual or agency obtain certification for individual services on the IFSP). The local system/Service Coordinator is responsible for assuring that the physician certifies the IFSP and that the physician certification is a part of the IFSP document. The local system may delegate this process, but only to one individual/agency so that physicians receive only one request for review and certification of the IFSP as a whole. If this responsibility is delegated to an individual/agency, that individual/agency must send the signed document to the local system to be filed with the IFSP in the child's EI record.
- Service coordinators are expected to make every effort to obtain physician certification quickly enough to ensure the timely start of services. Local systems are not permitted to delay the start of supports and services while waiting for insurance authorization or physician certification, except by parent request. If there is difficulty in getting timely physician signature from the child's primary care physician, service coordinators may seek a signature from another physician on the child's medical team or IFSP team or may be able to get the signature of a physician assistant or nurse practitioner associated with the physician.
- In those rare instances when the service coordinator is unable to obtain the physician signature in a timely manner, Part C funds must be used, as needed, to avoid a delay in the start of services. Remember that Medicaid allows the service to start without a physician signature and will still reimburse for the service as long as the physician (or physician assistant or nurse practitioner) signature is obtained no more than 30 days after the first IFSP services (other than service coordination) begin.
- Physical therapists must follow Virginia PT regulatory requirements governing physician referrals for services and will not be able to begin services without such a referral, except under the limited exclusions specified in the PT regulations, even if Part C funds are available as payor of last resort.

6. Ensure that if the family declines one or more early intervention services listed on the IFSP (but not all services listed on the IFSP), then the following steps occur:
  - a. Obtain the family's signature on the *Declining Early Intervention Services* form and provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*. Using the top half of the *Declining Early Intervention Services* form, fill in the date of the IFSP and the service(s) the family is declining. Both the service coordinator and family must sign and date the form.
  - b. Explain that the services that are not declined will be provided at the frequency, intensity and duration listed on the IFSP.
  - c. In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
  - d. Explain how the family may, at a later date, through the IFSP review process, accept a service previously declined.

Examples:

The top half of the *Declining Early Intervention Services* form would be used when:

- At an initial IFSP, annual IFSP or IFSP review, the rest of the IFSP team believes the child needs a particular service, but the family does not agree and does not wish to receive that service; or
- After a service has started, the family wishes to decline to continue receiving that service even though the rest of the team believes that service is necessary to achieve the outcomes.

7. Ensure that if the family declines all services listed on the IFSP, then the following steps occur:
  - a. Obtain the family's signature on the *Declining Early Intervention Services* form and provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*.
    - Using the bottom half of the *Declining Early Intervention Services* form, the family is asked to mark the third line (that their child is eligible and has the right to receive the services listed on the IFSP and that they do not choose to have their child receive services through the Infant & Toddler Connection system).
    - Explain to the family how they can contact the local Infant & Toddler Connection system in the future using the phone number provided at the bottom of the form if they have concerns about their child's development.

- In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
  - b. If the child is close to being age eligible for early childhood special education services through the local school division (under Part B), explain how to access Part B services through the local school division.
  - c. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.
  - d. Obtain parent consent to communicate with the primary care physician and primary referral source, if not already provided.
  - e. Document in ITOTS, within 10 business days of the family declining all services, that eligibility determination was completed and the child was either eligible/declined services or eligible/chose other services.
8. Ensure that if the family is requesting a specific early intervention service, or a specific frequency, intensity, location or method of delivering services that the rest of the team does not agree is necessary to achieve the outcomes identified on the IFSP, then the following steps occur:
- a. Provide a copy and explanation of the *Parental Prior Notice* form to the family. The “Other” line is checked and refusal to initiate the specific service is written in as the description. The reason why the Infant & Toddler Connection system is refusing to initiate the service is specified (e.g., progress made, other supports and services in place, evidence-based practice, etc.). If there is not enough space on the form to describe the reason for refusing to initiate the service, then additional documentation may be attached to the form and referenced in the “Reason” section of the form. Parent signature is obtained to acknowledge receipt of the form.
  - b. Provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System* to the family. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined. In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures.
  - c. For Medicaid recipients only: Complete and provide the family with the *Early Intervention Services – Notice of Action* letter and explain to the family their right to appeal under Medicaid if they disagree with the early intervention services listed on the IFSP. Point out where additional information about the appeal process is located in the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*.

Completion of these steps protects both the family and the local system, ensuring that the family understands their rights, safeguards and opportunities for addressing the disagreement if they so choose and that local systems have clear documentation of the service requested and reasons for refusing to initiate that service.

9. Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.

### Selecting Service Providers

1. Part C early intervention supports and services will be provided only by qualified Part C practitioners who are affiliated with the local system. Practitioners who provide service coordination or other early intervention services, except audiology, nutrition services and medical services, must be certified by the Department of Behavioral Health and Developmental Services as an Early Intervention Professional, Early Intervention Specialist or Early Intervention Service Coordinator. See Chapter 12 – Personnel for more information about practitioner qualifications, certification and affiliation with a local system.
2. The service coordinator assists the family to select a provider(s). The service coordinator:
  - a. Explains that the family has the opportunity to select from among the provider agencies (including independent practitioners) who are qualified to provide the service identified on the IFSP and who are in the family's payor network and who practice in the area where the child/family lives.
    - If no practitioner who can support and assist the family in accomplishing the IFSP outcomes is available within the family's Medicaid or private insurance network, then the family may choose a practitioner from outside their third party payor network.
    - If the family would like to receive services from a practitioner who is not affiliated with the local system but who meets the Early Intervention Certification requirements and who is within the family's payor network, the local lead agency should make arrangements with that practitioner to become affiliated with the local system.
    - The family may request a specific provider from within the selected provider agency.
    - If there is only one provider agency, then the family must be offered a choice of providers from within that one agency. If the family has a concern about receiving services from that agency, then the local system must work to identify an additional provider.

The family must be offered the opportunity to select a provider agency any time a new service is added or when a change in provider agency is needed.
  - b. Contacts the selected provider agency and arranges for a service provider(s). If the selected provider agency is unable to provide the service due to full provider caseloads or the requested service provider within that agency is unavailable, then the service coordinator explains to the family their option to begin services right away with an available provider or to wait for their chosen provider to become available. If the family chooses to wait, the service coordinator documents this decision

and the delay in start of services will be considered a family scheduling preference.

- c. Informs the family that they may request to change their service provider at any time by contacting the service coordinator.

It is possible that some families may not have a preference for a specific practitioner or provider agency. In those situations, the local system should have a mechanism in place for assignment of providers. There still must be documentation by parent signature on the IFSP addendum page that the parent was offered the opportunity to choose a provider. If the family's choice is to request the first available provider, then the family may sign the Addendum page prior to determining who the exact provider will be.

3. A targeted case manager (ID or MH) cannot provide both service coordination/TCM and another Part C service to the same child and family. (However, the targeted case manager may provide assessment as part of the initial assessment for service planning for the purpose of identifying service needs.)
4. The choice of service provider(s) is documented on the IFSP Addendum page, which may be completed after the IFSP itself is signed. The Addendum page documents not only the service provider selected but also the family's signature acknowledging that they were offered the opportunity to choose a provider.
  - a. If the family's choice is to request the first available provider, then the family may sign the Addendum page prior to determining who the exact provider will be.
  - b. Otherwise, the family's signature on the Addendum page may be obtained at the first visit with the family after provider arrangements have been finalized based on the family's choice.
  - c. No services, other than service coordination, can be delivered until the addendum page is signed (though it is acceptable for the provider to have the family sign the addendum page at his/her first visit if it has not already been signed).

#### ITOTS Data Entry – IFSP Development

The local system manager ensures the following information is entered into ITOTS:

1. Assessment data in the Child Indicator Assessment section:
  - a. Assessment date
  - b. The rating (1-7) for each of the three indicators: Positive social relationship, Acquiring and using knowledge and skills, and Taking appropriate action to meet needs.
2. If the family declines all services (and does not sign the IFSP), then within 10 business days of the family declining all services, indicate that eligibility determination was completed and the child was either eligible/declined services or eligible/chose other services
3. IFSP Completed? Yes/No
4. Date (IFSP Completed)
5. Mitigating circumstances if exceeded 45-day timeline
6. Primary service setting
7. Medically Fragile? Yes/No
8. Risk factors
9. Initial planned services
10. Third party coverage

[Complete ITOTS instructions are available at  
<http://www.infantva.org/documents/forms/INST1117eR.pdf>]

#### Local Monitoring and Supervision Associated with IFSP Development

The local system manager provides the supervision and monitoring necessary to ensure the following:

1. Procedural safeguards forms are used and explained appropriately.
2. The 45-day timeline for development of the initial IFSP is met.
3. Mitigating circumstances are documented when the 45-day timeline is exceeded.
4. Development of IFSPs is in accordance with the IFSP Instructions provided at the end of this chapter.
5. ITOTS data entry is timely and accurate.
6. IFSP outcomes reflect family priorities and routines and the child's functional abilities and needs.
7. Planned supports and services are appropriate to meet the outcomes.
8. Efforts to secure foreign language and sign language interpreters to assist the family's active participation in the IFSP meeting are documented.

## INSTRUCTIONS FOR COMPLETING THE VIRGINIA IFSP FORM

### **GENERAL INFORMATION**

- Virginia's statewide IFSP has been designed to meet the IFSP requirements of Part C of IDEA and Medicaid plan of care requirements under the Medicaid Early Intervention Services Program. In order to maintain the integrity and official identity of the statewide IFSP form, only the following changes are permitted:
  - Local System Name (Required) – Before completing or printing the form, delete the words “Local System Name Here” and enter the local system name. The local system name must be the Infant & Toddler Connection of \_\_\_\_\_ and not a program or provider name. The local system has the option to enter on the line below Infant & Toddler Connection of \_\_\_\_\_, “Administered by {name of local lead agency}.”
  - Child's County or City of Residence (Optional) – If the local system serves only one county or city, that information may be added permanently to the form (i.e., pre-printed). Other local systems may permanently add the list of counties and cities served to the extent that they fit in the available space (the applicable county or city can then be circled when the IFSP is completed).
  - Service Coordinator's Name, Agency, Address, etc. (Optional) – If all service coordinators in the local system work from one agency, then that agency information may be permanently added to the form (pre-printed) on page 1. Leave the top space blank in order to enter the Service Coordinator's name, but add all consistent information to the permanent form.
  - Those local systems that are currently using the IFSP to meet Targeted Case Management (TCM) Consumer Service Plan requirements may use their existing social assessment prompts on the IFSP rather than using Section IIc. It is acceptable to have the social assessment prompts in existing sections of the IFSP and delete section IIc, but the addition of prompts to address information beyond what is required for the Person Centered Individual Support Plan is not allowed. Once the IFSP form is changed by the local system, it is no longer the document that was reviewed and approved by the Department of Medical Assistance Services.

**No other prompts or information may be added or pre-printed on the statewide IFSP form.**

- The form may be filled out electronically, or printed out and completed in handwriting, or through a combination of both. Instructions for using word processing to make the permitted changes described above and to complete the form electronically are provided in Attachment A of these instructions.
- Electronic signatures are acceptable if your local system has a mechanism to accommodate electronic signatures.
- All dates must be provided as month, day, and year.

- If/when errors are made when completing a handwritten IFSP for an individual child, they must be crossed out with a single line and initialed and dated by the reviser. Correct errors in an electronically-completed IFSP by following local agency requirements or by using strike-through and providing the date and initials of the reviser. White-out, or any other means of correction other than that described here, may never be used.
- The Child's Name, Date of Birth, and IFSP Date are to be filled in at the top of each page after page one. This ensures that if pages of the IFSP become separated, each page will be easily identifiable. The IFSP Date and Date of Birth on each page help to further identify the child in case more than one child in a program has the same name and also serves to identify the IFSP in case the initial and/or subsequent IFSPs in a child's file become mixed together.
- Each section of the IFSP should be filled in (except that "Date Met" and "Date Outcome Added" do not need to be completed on page 5 of the initial or annual IFSP; items on the transition page should be filled in over time, as appropriate; and Child's Primary Language may be left blank if it is the same as the family's). If an item is non-applicable, place "N/A" in that space. If a space seems to ask for unnecessary or redundant information, review the instructions to ensure you have correctly interpreted the intent of the item.
- When columns are used, if the information is the same for each cell in the column, it is permissible to write "above" in each cell of the column after the first one.
- If a child with a current IFSP moves within Virginia, communication and coordination should occur between the sending local system and the receiving local system in advance of the move, whenever possible, to enable supports and services to be in place in the receiving local system based on the current IFSP. The family's new service coordinator will schedule an IFSP review soon after the family moves in order for the new IFSP team to review the existing IFSP and make any necessary modifications. The revised IFSP must reflect the new local system name; new service coordinator; new demographic information (city/county, family contact information); any changes to outcomes, supports and services (based on child and family needs); and a completed IFSP review page (page 9) with parent signature. Since there will be new information in several sections of page 1, it may be easiest to create a new page 1 for the IFSP. In this case, maintain the old page 1 in the child's early intervention record. [Please note that when entering the IFSP date in ITOTS for a child who has transferred from another local system in Virginia with an active IFSP, the original IFSP date (the date on the IFSP he/she had in the previous system, rather than the date of the new review) is used.]
- An alternate version of the statewide IFSP has been developed to address Person Centered Individual Support Plan requirements associated with the provision of Intellectual Disabilities Targeted Case Management (TCM-ID). This alternate version is labeled Infant & Toddler Connection of Virginia – IFSP, TCM in the footer of the IFSP form; and instructions for completing the TCM-ID version of the IFSP are provided in Attachment B of these instructions. Use of the TCM-ID version of the IFSP is optional and is not limited to children who are eligible for TCM-ID.



## **PAGE 1**

### **I. Child and Family Information**

The information on this page is primarily for the purposes of Part C. Other demographic information required by third-party payors (e.g., Social Security number, insurance policy number/s, diagnosis codes) and possibly by individual local Part C systems (e.g., program ID numbers) is highly specific to individual companies, confidential, and irrelevant to many of the recipients of an IFSP (e.g., local school systems, childcare providers). Therefore, it should be provided, as required by individual circumstances, on a separate page as an attachment.

- 1) **Child's Name** - Fill in child's name
- 2) **Date of Birth** - Fill in child's date of birth
- 3) **Gender** – Check M or F to indicate whether the child is male or female
- 4) **Child's County or City of Residence** - Fill in child's city or county of residence. This is important for local systems that have more than one city or county in their catchment area. This may be pre-printed on the form for local systems who only serve one city or county. Other local systems may permanently add the list of counties and cities served to the extent that they fit in the available space (the applicable county or city can then be circled when the IFSP is completed).
- 5) **IFSP Date** - Enter the date the parent signs the IFSP (i.e., the IFSP Date on page 1 and at the top of subsequent pages must match the date of parent signature on page 8 of the IFSP). If the IFSP cannot be completed in one meeting, then the contact notes must reflect the dates of all meetings held to develop the IFSP.
- 6) **Initial/Annual** - Check the appropriate box to indicate if this is the child's initial IFSP or if it is an annual IFSP and write in which annual IFSP it is (e.g., #1, #2. The annual IFSP done one year after the initial IFSP is annual #1).

If the IFSP form is used for an interim IFSP, then "Interim IFSP" should be hand-written on the cover page. When the initial IFSP is developed, the team starts with a new IFSP form.

- 7) **Date Six-Month Review Due** - Fill in the date by which the six-month IFSP review must be completed. This date will be 6 months from the IFSP Date entered above.
- 8) **Date(s) Review(s) Completed** – When the 6-month or other IFSP review is conducted, write in the date of the review. It is not necessary to rewrite the IFSP at every six-month review or when a review is held at a time other than 6 months, as long as the IFSP is updated to reflect the child's current needs and plans. However, a new IFSP form must be initiated at each annual IFSP meeting.
- 9) **Family's Primary Language and/or Mode of Communication** - Fill in the family's primary language or mode of communication. (Examples: English, Spanish, American sign language, augmentative communication system)

- 10) **Child's (if different)** - Fill in the child's primary language or mode of communication, if different from the family's. If it is the same, leave blank.
- 11) **Medicaid Number (Optional)** – If the child has Medicaid, the team may choose to enter the number here. This should be the child's permanent 12-digit Medicaid number (as opposed to a MCO number, for instance).
- 12) **Family's Name, Address, Phone, And Other Contacts** – Fill in all contact information for the family. The amount of space in this section allows for the wide range of potential *contacts* required, (e.g., surrogate parents, foster parents, social services or natural parents, child care provider), the variety of *methods* of contact possible for each contact listed (e.g., home phone, work phone, cell phone, pager, e-mail, personal fax), and allows room for updates as information changes. Some local systems may also wish to include the physician's name and contact information in this section. [When completing the IFSP electronically, this section is formatted into 2 columns. The section will allow you to continue entering information in column one until you click into column 2. You will need to click into column 2 when the last information on page 1 is at the bottom of the page (i.e., before it scrolls onto a new page).]
- 13) **Service Coordinator's Name, Agency, Address, Phone and Fax Numbers** – Fill in all contact information for the family's service coordinator, as assigned at the IFSP meeting, including if appropriate, cell phone, pager, e-mail, etc.

Some families may prefer to handle most or all of their own service coordination duties; it is still a requirement of Part C, however, that they have an official service coordinator assigned.

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## **PAGE 2**

### **II a. Child and Family Activities**

Fill in information regarding the family's everyday activities and routines, including what is going well for the family, what challenges they have with specific routines, what the child and family normally enjoy, and what changes they would like to see in their routines and activities. This information will guide development of strategies for achieving outcomes within the context of the child's and family's interests and naturally occurring activities, routines, and community supports. The information may be presented as a narrative, phrases, a diagram, or other format.

The service coordinator is expected to gather information for Sections IIa and IIb prior to the IFSP meeting, through conversations with the family beginning at the initial visit with family. This practice will assist families and providers in preparing for the development of outcomes during the IFSP meeting. Page 2 of the IFSP may be completed prior to or finalized during the IFSP meeting.

## **II b. Family Identified Resources, Priorities, & Concerns**

Record information shared by the family about their resources, priorities, and concerns related to enhancing their child's development. This section must also include the family's assessment of the supports, resources and services they currently have. Families help identify other caregivers in the child's life who may be able to assist in addressing the IFSP outcomes. The extent to which other caregivers (such as child care providers, extended family members, respite care providers, etc.) are involved in addressing IFSP outcomes depends on a number of factors including, but not limited to, the following: the extent to which the family would like to have these other caregivers involved, how much time the child spends with these caregivers, and the willingness of these caregivers to learn and apply strategies for increasing the child's learning opportunities and ability to participate in everyday activities. The service coordinator is responsible for informing the family that inclusion in the IFSP of information from a family-directed assessment related to enhancing the development of the child is voluntary and refusal to include such a statement in the IFSP in no way jeopardizes the supports and services provided as part of the IFSP. The information may be presented as a narrative, phrases, a diagram, or other format. If the family declines to provide this information or provides this information but does not want it to be included on the IFSP, they are to initial the appropriate statement in the box on page two of the IFSP form.

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## **PAGE 3:**

### **III. Team Assessment**

- 1) **Narrative** - Provide a written summary of the child's development. This section may be organized in any manner. An integrated report describing the child's developmental status and functional skills across developmental domains and summarizing the findings from all assessment sources is strongly recommended.

If assessments completed outside the Infant & Toddler Connection of Virginia system are used, then these should be referenced in the summary on page 3. In order for the narrative to give a complete picture of the child's developmental status it is helpful to integrate relevant information from the outside report(s) into the team assessment. Any outside assessment reports used must be included in the child's record and may be attached to the IFSP.

In order to avoid duplication of assessments, the IFSP team may use assessment reports written by providers outside of the Infant & Toddler Connection of Virginia for development of the IFSP and service planning. When using outside assessment reports, relevant information must be transferred from that assessment report to page 3 of the IFSP, so that it is clear that all required Part C assessment components have been completed. If a provider from outside the Infant & Toddler Connection of Virginia assessed only some, but not all, of the developmental areas required by Part C, the remaining areas of development must be assessed during the assessment for service planning. Assessments must have occurred no more than 6 months prior to being used for service planning.

If more than one page is required, a second Page 3, entitled "Narrative" is available for those who complete the IFSP by hand. When the IFSP is completed electronically, the narrative will automatically continue onto additional pages as needed. For each additional page, the preceding page should reference the continuation onto the next page.

In order to document medical necessity for third party payors the narrative must include the following information: the referral source and reason for referral, any medical diagnoses (especially those related to the reason for referral), pertinent health and physical development information (including pertinent medical history, clinical signs and symptoms, current health status), and a summary of developmental/functional strengths and limitations.

- 2) **The following people participated in the assessment for service planning** (printed name, credentials, role/ organization, signatures, date) – Individuals who completed assessments should print their name, role/organization/credentials, as appropriate, and sign and date (month, day, year) here. For example:

Mary Anderson, Parent	<i>Mary Anderson</i>	9/15/09
Cathy Jones, OTR, Independence, Inc.	<i>Cathy Jones</i>	9/15/09
Debbie Smith, SLP, ABC Therapists Inc.	<i>Debbie Smith</i>	9/15/09

The narrative must be completed (written) before requesting signatures from any team member.

- 3) **Information from the following assessments completed outside the Infant & Toddler Connection of Virginia system was used to complete the assessment for service planning** (printed name, credentials, organization) - The name, credentials and organization of any assessor who is not part of the Infant & Toddler Connection of Virginia system must be entered here.

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#### **PAGE 4:**

**IV. Outcomes of Early Intervention – Service Coordination** - This page documents the outcome (pre-printed) and short-term goals for service coordination and must be completed for every child who has an IFSP, even if the family wishes to have only minimal service coordination from the local system and wants the service coordinator only to coordinate IFSP meetings. Parts of the page are partially completed in order to assure inclusion of required activities.

- 1) **Short Term Goals** – The short-term goals provide the Part C-required **criteria** for determining the degree to which progress is being made toward achieving the outcome. The short term

If the family only wants to address the two pre-printed short-term goals, then the rest of the lines for short-terms goals may be left blank. If the family only wants to address the first (pre-printed) short-term goal, then the other pre-printed short-term goal may either be deleted (if the IFSP is completed electronically) or struck through and initialed by the service coordinator (if the IFSP is handwritten).

goals should be written from the perspective of what the service coordinator will do for the child and family and must include a target date. The short-term goals should be specific and based on family priorities and needs at the time the IFSP is developed.

- 2) **Target Date (for short term goals)** – Provide target dates (month/day/year) for when each short-term goal could be expected to be achieved. The two pre-printed short-term goals are ongoing, and this has been pre-printed under Target Date.
- 3) **Date Met (for short term goals)** - Enter date (month/day/year) at any point at which the short-term goal was met, changed or discontinued. This date must correspond to information documented in the contact notes in the child's record.

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## **PAGE 5:**

Outcomes are identified based on information gathered through the assessment for service planning process, including conversations with the family to identify current activity settings, potential child learning opportunities and areas where the family would like assistance. Asking families questions like “What activity settings that your family participates in are most important to you?” and “What new activity settings would you like to pursue?” can assist families and the IFSP team in identifying the desired outcomes.

Each outcome must be recorded on a separate page. This outcome page is to be duplicated and used for all outcomes other than service coordination. Each outcome should be numbered (e.g., since the service coordination outcome will be outcome #1 for all children, subsequent outcomes should be numbered from # 2 on).

### **IV. Outcomes of Early Intervention**

- 1) **Date Outcome Added** – For outcomes developed at the initial IFSP meeting, this space is left blank. For outcomes added during IFSP review meetings, enter the date of the IFSP review during which the outcome was added (this is the start date for the new outcome). Page 9 of the IFSP must also be completed when an IFSP review is held.
- 2) **Outcome** (Long-term functional goal) # \_\_\_\_ - This statement is what the family would like to see happen as a result of their participation in Part C. It may be a major developmental goal related to the child's participation in home and community activities (child outcome), or it may be an outcome related to the family's ability to assist appropriately in their child's development (family outcome). It must be functionally stated, reflect the family's priorities (i.e., the outcome focuses on the child's participation in activities that are important to the family), and be consistent with information gathered from the team assessment of the child's developmental strengths and needs and with information from the family-directed family assessment (if completed). Outcomes can be stated in the family's words or they can be restated with help from the early intervention providers either in addition to the family's statement or instead of it if the family prefers. Child outcomes must be measurable and functional and represent what

the child is expected to be able to do, e.g., "Jane will feed herself the entire supper meal each day".

- 3) **Target Date** – Enter the date (month/day/year) by which the Outcome could reasonably be expected to be achieved. Since an IFSP Review must be held anytime changes are made to the outcome (and/or short term goals), it is helpful to choose a target date that corresponds to a required review date.
- 4) **Date Met, Changed Or Ended** – Enter date (month/day/year) at any point at which the Outcome was met, changed or discontinued. The change this date represents must be documented in contact notes in the child's record. An IFSP review must be held in order to change an outcome.
- 5) **Learning opportunities and activities that build on child's and family's interests and abilities** – List here activities that the child finds (or might find) enjoyable (based on child's interests and ability) and that could be incorporated into the child's and/or family's existing or desired routines and activities. This should not be an exhaustive listing of all the activities possible, but rather an overview of the possible activities that will be explored in ongoing intervention (specific activities will be recorded in ongoing contact notes/lesson plans). All intervention should, however, be planned in the context of the family's daily routines, activities, and resources available in the community, consistent with the information recorded in Section II of the IFSP.
- 6) **Short Term Goals** – The short-term goals provide the Part C-required **criteria** for determining the degree to which progress is being made toward achieving the outcome. The short term goals should be written from the perspective of what the child will be able to accomplish, should represent an end result rather than a process, should be **functional and measurable**, and must include a target date. The short-term goals can be thought of as the building blocks leading up to achievement of the outcome, e.g., *"Child will pull to stand while holding on to the sofa in the family room several times each evening without physical assistance."*
- 7) **Target Date (for short term goals)** – Provide target dates (month/day/year) for when each short-term goal could be expected to be achieved.
- 8) **Date Met (for short term goals)** - Enter date (month/day/year) at any point at which the short-term goal was met, changed or discontinued. This date must correspond to information documented in the contact notes in the child's record.
- 9) **Interventions (Treatment procedures and/or modalities)** – Enter the specific interventions (treatment procedures and/or modalities) that will be used to address the outcome. Specific interventions may include, but are not limited to, the following:

Balance/coordination	Equipment/device training
Positioning	Weight-bearing
Therapeutic exercise	Range of motion
Gait training	Caregiver/parent training
Community living skills	Fine motor training
Functional activities/mobility	Developmental handling
Assistive technology devices	Expressive language skills

training  
 Visual perceptual skills training  
 Receptive language skills  
 training  
 Feeding  
 Oral motor skills development  
 Swallowing  
 Pre-verbal skills  
 Cognitive skills development

Sign language  
 Behavior modification  
 Hearing aid tolerance/use  
 Sensory integration  
 Functional visual skills  
 Self-feeding skills  
 Articulation therapy/  
 phonological awareness  
 Cognitive linguistic therapy

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**PAGE 6:** Services Needed to Achieve Early Intervention Outcomes

**V. Services Needed to Achieve Early Intervention Outcomes** – Determine the specific Part C services that are necessary to help the child and family achieve the outcomes identified in Section IV of the IFSP. The IFSP team considers multiple factors when identifying appropriate supports and services to address IFSP outcomes, including the expertise needed to support the family, abilities and interests of the child and family, and family and community resources.

**Complete the table as follows:**

- 1) **Entitled Service** – Service coordination must be provided to every eligible child and family and has already been recorded in the table. Enter each additional Part C service that was determined through the IFSP process to be necessary for the child/family to achieve the outcomes identified in the IFSP. The following list of Part C services is not exhaustive and does not preclude the IFSP team from identifying another type of service as an early intervention service as long as that service meets the criteria of an early intervention service under Part C (i.e., services that are provided under public supervision, by qualified personnel, in accordance with the State's system of payments, selected in collaboration with the family, and designed to meet the developmental needs of the child or the needs of the family to assist appropriately in the child's development):

Assistive technology devices and services\*  
 Audiology  
 Developmental services (previously called Special instruction)\*\*  
 Counseling services  
 Health services  
 Medical evaluations  
 Occupational therapy  
 Physical therapy  
 Psychological services  
 Service coordination  
 Social work services  
 Speech-language pathology  
 Transportation and related costs  
 Vision services

**\*Important information about Assistive Technology:**

- When listing assistive technology on the IFSP, please specify whether it is an assistive technology device or assistive technology service.
- When listing Assistive Technology Device, the intensity, individual/group, and location should all be marked N/A. The projected end date and actual end date should reflect the anticipated and actual date of delivery of the device to the child, respectively.
- It is not necessary to list Assistive Technology Device on page 6 of the IFSP when the provider is trying out potential equipment with a child to determine whether or not it is appropriate to meet the child's and family's needs and the IFSP outcomes. Once an appropriate assistive technology device has been identified and will be acquired for this child (through loan or purchase), an IFSP review is held to add this device(s) to the entitled services listed on page 6 of the IFSP.
- Assistive technology services should be listed according to the provider of that service (e.g., if the assistive technology service is being provided by the physical therapist, then list the service as Physical Therapy/Assistive Technology Services). The frequency, intensity, method, etc. should reflect both the physical therapy service and assistive technology service, combined.
- Assistive technology services are services that directly assist the child with a disability in the selection, acquisition or use of an assistive technology device and include the following: evaluation of the needs of the child with a disability, including functional evaluation of the child in the child's customary environment; purchasing, leasing or otherwise providing for the acquisition of assistive technology devices; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices; coordinating and using other therapies, interventions or services with assistive technology devices, such as those associated with education and rehabilitation plans and programs; training or technical assistance for the child, family, other caregivers or service providers; and collaboration with the family and other early intervention service providers. If a provider is delivering any of the services included in the definition of assistive technology services, then page 6 of the IFSP should reflect both the service that provider generally provides (e.g., physical therapy if the provider is a physical therapist) and assistive technology service as indicated above.

A subsequent page in these instructions provides an example of how to record an assistive technology device and service in the Entitled Services table on page 6 of the IFSP.

**\*\*Developmental Services Provided by Nurses:**

- List "developmental services" as the service on page 6 of the IFSP even when that service is provided by a nurse.
- When billing for developmental services provided by a nurse the provider will use billing codes G0154/G0154 U1 for services in natural environments and T1026/T1026 U1 for center-based services. Similarly, when a nurse is providing assessment, participating in IFSP meetings, team treatment activities, etc., the appropriate billing codes are T1023 U1 and T1024 U1. Billing code descriptions are provided in Chapter 11.



Entitled Service Versus Intervention/Treatment Modality:

Auditory Verbal Therapy (AVT) and Applied Behavior Analysis (ABA) or other such approaches to service delivery are not entitled Part C services; but rather interventions/treatment modalities. The IFSP must list the entitled Part C services based on the provider who will implement the intervention/treatment modality (e.g., if the IFSP team determines that a speech-language pathologist will be implementing AVT to address the outcomes for a given child, then speech-language pathology is the entitled service listed on the child's IFSP).

## V. Services Needed to Achieve Early Intervention Outcomes

ENTITLED SERVICE	FREQUENCY (# x/wk/ month/once)	INTENSITY (# min/visit)	GROUP (g) / INDIVIDUAL (i)	METHODS** (a,b,c,d)	NATURAL ENVIRONMENT/ LOCATION  (Must be a natural setting unless justified below)	PAYMENT  1. Family Fee 2. Insurance 3. Medicaid, 4. State Funds 5. Local Funds 6. Part C	PROJECTED START DATE	PROJECTED END DATE	ACTUAL END DATE
1. Service Coordination	*	*		Service coordination					
2. Assistive technology device	NA	NA	NA	d	NA	donation	12/31/09	12/31/09	
3. Physical therapy/Assistive technology services	2/mo	60 min	I	a	home	3	12/1/09	6/1/10	
4.									
5.									
6.									
7.									
8.									
* This is the minimum frequency and intensity of direct contact from your service coordinator. The frequency and intensity of service coordination actually provided will vary since service coordination is an active, ongoing process that changes based on your family's priorities and needs.									
** Methods:    a = Coaching, including hands-on as appropriate                      b = Consultation            c = Assessment d = Provision of assistive technology device									

### EXAMPLE OF HOW TO RECORD ASSISTIVE TECHNOLOGY DEVICES AND SERVICES ON PAGE 6 OF THE IFSP

- 2) **Frequency** - Enter the number of visits per week/month each service is to be provided (e.g., 1x/wk). ***It is not acceptable to list a range (such as 1-2x/week) for frequency.*** It is acceptable to plan for and record a change in frequency of a service, such as weekly occupational therapy for two months, then occupational therapy every two weeks for three months. If a service will be provided only once, then write “once” in the frequency column.

For service coordination, record the projected **minimum** frequency of **direct contact time between the service coordinator and the family**, which includes activities such as home visits, phone calls and emails with the family, accompanying the family to an appointment, etc.

- 3) **Intensity** - Enter the length of time the service is to be provided during each visit (e.g., 60 min/visit). ***It is not acceptable to list a range (such as 30-45min/visit) for intensity.***

For service coordination, record the projected **minimum** intensity of **direct contact time between the service coordinator and the family**, which includes activities such as home visits, phone calls and emails with the family, accompanying the family to an appointment, etc.

#### Frequency and Intensity for Service Coordination

The Part C Office recognizes that the frequency and intensity of service coordination actually provided will fluctuate since service coordination is an active, ongoing process that is responsive to individual family needs and circumstances. When the frequency and intensity of service coordination delivered vary from that planned on isolated occasions, the service coordinator's contact notes must reflect the reason for increase/decrease in frequency/intensity. If the frequency and/or intensity of service coordination delivered vary greatly from that planned on a consistent basis, then it is time for an IFSP review. During State monitoring of service delivery, local systems will NOT be cited as out of compliance if there is not an exact match between the planned and delivered frequency and/or intensity for service coordination as long as there is documentation that service coordination was active and ongoing and based on meeting the family's needs and IFSP outcomes.

#### A Question about Frequency and Intensity

**Question:** Can the total amount of minutes for a service be listed for the month on page 6 of the IFSP? For example, could an IFSP state “240 minutes a month” for a service and then could those minutes be divided in any way the provider and family agree during the month?

**Answer:** The IFSP needs to give the family (and providers) a reasonable expectation as to frequency and intensity of services. The proposed “240 minutes a month” is too wide-open, giving no structure to scheduling and planning for the service that would ensure the service is reasonably designed to address the IFSP outcome(s). We see in this question a desire for flexibility, presumably to meet child and family needs, and a commitment to providing services at the frequency and intensity listed on the IFSP. While you are required to meet the frequency and intensity of services listed on the IFSP, this does not eliminate flexibility to meet child and family needs. For instance, the child’s IFSP may list developmental services once a week for 60 minutes. If a particular visit needs to be cut short, maybe 45 minutes into the visit the family gets a phone call and needs to leave to handle an urgent family matter, then the remaining 15 minutes of that visit can be “made up” by adding 5 minutes each to the next 3 visits, or adding 15 minutes to the next visit, etc. The arrangements for making up the time must be documented in a contact note. If you consistently find that the planned frequency or intensity is not working, then it is time to hold an IFSP review or consider whether a different day or time of day would fit better in the child’s and family’s schedule and routine.

- 4) **Group/Individual** – Specify whether the service is to be provided on an individual or group basis. Although Part C services are most often provided on an individual basis, an example of when group might be listed as the method would be when one service provider is working with twins, who are both eligible for Part C, in the home, together on a shared outcome.
- 5) **Methods** – Using a, b, c, or d, specify whether the service is to be provided through coaching, including hands-on as appropriate; consultation; provision of an assistive technology device; or assessment.
  - Coaching, including hands-on as appropriate – Record this method any time the provider will provide a service (other than assessment, see below) to the child and/or family and/or other caregiver.
  - Consultation – This method refers to consulting between service providers (i.e., the child and family are not involved in the consultation session). The IFSP will list the service (discipline) that is providing the consultation.
    - If the consultation between providers is planned at the time of the IFSP, then it should be documented as an entitled service on page 6 of the IFSP. If a concern comes up later and the primary provider is just making a call to another provider, say the OT, to ask a question, then there is no need to have an IFSP review to record that call as consultation. However,

depending on the outcome of that call, an IFSP review may be needed in order to add assessment or further consultation by the OT.

- Consultation between team members who are both providing ongoing services to the child using the method “coaching, including hands on as needed” is not listed on the IFSP as consultation between the two providers (without the child and family). Instead this is considered teaming, an expected part of service delivery that is included in the EI rate paid for the service they are already providing.
  - Provision of an assistive technology device – Record this method only when the service listed is Assistive Technology Device.
  - Assessment – This method refers to assessment completed after the initial assessment for service planning and does not include ongoing assessment conducted at each session by the service provider.
- 6) **Natural Environment/Location** - Enter the natural environment/location where the service will take place. The choice of location is based on the activities that are being addressed (as identified in the outcomes on page 5 of the IFSP). For services that will be provided in a variety of community settings, it is acceptable to record several of the locations followed by "etc." ("park, home, daycare, grocery store, etc."). If listing two locations (for example, "daycare and home"), connect the two with "and" so that it is clear that both locations will be used.

If the location is not a natural environment, provide justification (in the designated place on page 6) for why the IFSP outcomes cannot be met in a natural environment.

For service coordination, if the family wants contact to be by phone and e-mail, the service coordinator will see the family face-to-face at least for the annual IFSP. In this situation, the location listed on the IFSP would be the location where the service coordinator will be with the family for the annual IFSP meeting.

- 7) **Payment** – Using the key in the header of this column, list the number(s) of the possible payment sources for each service. The final decisions about payment arrangements are recorded on the Family Cost Share Agreement form. Possible payment sources may include Medicaid, private insurance, family fees, donation, state, city, Part C funds, etc. If a possible payment source is not listed in the key, then write it in the appropriate box (see the example on page 14 of these instructions). “None” is not an option.
- 8) **Projected Start Date** - Enter the **projected** date (month/day/year) on which the service will begin. The exact date of the first appointment is not required. The date should be within 30 calendar days of the date the parent signs the IFSP unless the IFSP team decides on and documents the reasons for a later start date in order to meet the individual needs of the child and family. It is not permitted to delay services while waiting for insurance authorization, except by

parent request. The projected start date for a one-time service (e.g., an audiology evaluation) should reflect the anticipated date for delivery of that service. The IFSP is not valid or in effect until the parent signs the IFSP. The IFSP date would be listed as the projected start date only if (1) the family signs the IFSP on that date and (2) the service is anticipated to be delivered that same day.

Please note that the 30-day timeline does not apply to delivery of an assistive technology device. The projected start date listed on the IFSP for an assistive technology device should reflect the anticipated date for delivery of that service/device.

- 9) **Projected End Date** – Enter date (month, day, and year) when the service can reasonably be expected to have met all outcomes, or a future IFSP review date. The projected end date for a one-time service would be the same as the projected start date.
- 10) **Actual End Date** - Enter the date the service, as written, was discontinued. This applies to discontinuation of the service, and it also applies to any **changes** in the service, such as a change in the frequency, intensity, method, or location. In the latter cases, the service as originally written on the IFSP has been discontinued. Accordingly, the date of the change (End Date) should be entered here, and the “new” service (reflecting the changes made) should be added on the next empty line. Changes of this sort require an IFSP review and must be documented in Section IX – IFSP Review Record. For example, if the service on the IFSP is listed as physical therapy, 2 times per month, 1 hour per session, coaching with hands-on as appropriate, on an individual basis at home, then the actual end date for that service, as written, means the actual end date for physical therapy provided at that frequency, intensity, method, location. Physical therapy may be continuing but the frequency has been changed to once a month – the previous physical therapy service, as written, has ended and the new physical therapy service has begun.

When an annual IFSP is developed, the actual end dates must be completed for each service on the previous IFSP (the IFSP that ends when the annual IFSP is developed). To do this, write “continuing” in the actual end date column for those services that will continue, as written, on the annual IFSP. Fill in the actual last date of service for any services that will not continue, as written, on the annual IFSP.

**Justification of why early intervention outcomes cannot be achieved satisfactorily in natural settings and a plan with timelines and supports necessary to return early intervention services to natural settings** – If any service will be provided outside of a natural setting, explain here why outcomes cannot be achieved by receiving services in a natural setting within the context of the daily activities and routines of the child and family. The justification must document the IFSP team’s decision that the child’s outcome(s) could not be met in a natural setting even with supplementary support (e.g., adaptations or modifications to activities or environments; use of assistive technology). The justification must include ways that services provided in specialized settings will be generalized into the child’s daily activities and routines and a plan with steps, timelines and supports necessary

to return early intervention services to natural settings within the child's and family's daily activities and routines. The need for services to continue outside of natural settings must be monitored carefully, and IFSP reviews should be held more frequently to determine whether the child's outcomes can now be met within natural settings. Therapist or parent preferences are not acceptable justifications. (If services are not provided in natural settings within the context of the daily activities and routines of the child and family because of family preference, then the services are not Part C services and cannot be paid for with any federal, state or local early intervention funds).

**Reason for later projected start date (if services are planned to start more than 30 calendar days after the family signs the IFSP)** – For each service that is planned to start more than 30 calendar days after the family signs the IFSP, list here the service and indicate whether the reason is family scheduling preference, team planned a later start date to meet child and family needs, or other. If the reason is that the team planned a later start date to meet child and family needs, then explain here or in a contact note how the delay in the start of services meets child and family needs. If the reason is “other,” then this other reason must be fully documented/explained in the contact notes.

IFSP services may start more than 30 calendar days after the family signs the IFSP and still be considered “timely” if the IFSP team decides on and documents the reasons for a later start date in order to meet the individual needs of the child and family. It is also acceptable to plan a later start date due to family scheduling preference.

Provider unavailability is not a reason for planning a later start date, since it is not known for certain at the time of IFSP development that there will be no provider available. There are circumstances when the IFSP team anticipates a delay in the start of services due to a provider issue. For instance, if audiology is listed as an entitled service and the team knows it usually takes 6 weeks to get an appointment, then the projected start date should be realistic and reflect that fact. The reason for the later projected start date would be “other,” and the local system will work to get an earlier appointment either through a cancellation or by seeking the services of another audiologist, if possible. The contact notes will document the attempts to get an earlier appointment. Similarly, if the team anticipates a delay in the start of physical therapy because of a provider shortage, then the projected start date will reflect that fact, the reason given will be “other,” and contact notes will detail the circumstances as well as efforts to start the service as soon as possible.

Local systems are not permitted to delay the start of supports and services while waiting for insurance authorization, except by parent request. In order for this to be considered an acceptable reason for the delay in starting a service(s), there must be documentation that contact has been ongoing with the insurance company and that the local early intervention system has been working with the company to determine if there will be coverage for early intervention services AND that the parent chose not to begin services until insurance issues were resolved. Otherwise, Part C funds must be used to avoid a delay in the start of services.

If a service has a projected start date on the IFSP that is within the 30-day time frame, but the actual start date is delayed beyond the 30 days, then the reasons for that delay are documented in the contact notes rather than on the IFSP. The contact notes also provide documentation of the actual start date of each service. Compliance with the requirement for timely start of services is based on the actual start date in relation to the date the family signed the IFSP.

**VI. Other Services (*services needed, but not entitled under Part C –include medical services such as well baby checks, follow up with specialists for medical purposes, etc.*)** – List all medical and any other ongoing services a child and/or family may need but are neither required nor covered under Part C, e.g., follow-up by a medical specialist for a chronic health condition, orthopedic visits, etc. For each service, list the name of the provider of the service and the location at which the service is typically rendered. If those services are not yet being provided, describe the steps the service coordinator or family may take to assist the child and family in securing those services.

**Entitled vs. Other:**

- Any medical services for diagnostic or assessment purposes that the IFSP team identifies as necessary to determine the child's developmental status are considered entitled services and should be listed in the entitled services section.
- Services parents secure on their own outside of Part C (because they want more frequent services or a specific location, for example) should be listed as Other Services.

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**PAGE 7:**

**VII. Transition Planning** - The activities on this page are intended to help service coordinators plan individual child/family transitions in compliance with Part C requirements. There is no specific requirement about how much of the transition planning page must be completed at the initial IFSP. However, all blanks within this page (except "other steps/activities") must be completed by the time the child transitions. If the child will receive no further services upon leaving early intervention, then non-applicable activities (e.g., sending child referral information to the next setting) should be marked "N/A." Transition planning must be individualized for each child and family and take into account the child's age at the initial IFSP as well as the family's priorities and preferences.

The transition pages of the IFSP should be updated more frequently as the time of the child's transition draws nearer. An IFSP review is not needed in order to make changes on the transition pages. The family and service coordinator may update or make changes to the transition pages and then share the updated information with other team members at the time of the next IFSP review or annual IFSP.



- 1) **The following information about transition is discussed beginning at the initial IFSP** – This box provides an outline of the general information about transition that must be shared with families beginning at the initial IFSP meeting. Enter the date this information was fully shared with the family and the initials of the service coordinator. It is acknowledged that this information may be discussed with the family on more than one occasion, but it is only necessary to document the date on which the information was first reviewed completely with the family.
- 2) **Important Dates for Transition Planning** – This information assists the service coordinator and family in knowing some of the important dates for transition planning with this specific child and family.
  - **Target date for referral to determine eligibility for early childhood special education services** – Generally, local systems will enter April 1 of the year that the child will be 2 by September 30<sup>th</sup>. This date provides the target date for referral to the local school division in order for the child to begin receiving early childhood special education services on the first day of school. Some local systems may work with local school divisions that allow admission of 2-year-olds throughout the school year (rolling admissions) or have other agreed upon timelines for referral. In that case, enter the target date here accordingly.
  - **Date of child's third birthday** – Enter the date of the child's third birthday and discuss with the family the eligibility and age requirements for early intervention so they understand their child will not be eligible for Part C early intervention services on or after the child's third birthday.Both target dates (for transition at age 2 and at age 3) must be completed.
- 3) **Notification to the Local School Division** – Enter the date by which the child's name, address, phone number and birth date will be sent to the local school division and enter the name of that school division. For children who are potentially eligible for Part B, the local Part C system is required to send the child's name, address, phone number and birth date to the local school division as the child becomes age eligible, unless the parent initials the line in this box indicating they do not want this information transmitted. Children in Part C are considered "potentially eligible" for Part B unless there is a clear expectation that they will no longer require services by the time they reach age 3. In Virginia, children are age eligible for Part B services at the start of the school year in which the child is 2 by September 30. Therefore, the date entered in the notification box must be no later than the April 1 prior to the start of the school year in which the child turns 2 by September 30. If the parent opts out of notification at that time, they may use the "I have changed my mind..." line in the Notification box on page 7 of the IFSP to allow notification at a later time, as their child approaches age 3.

When/if the notification is actually sent, enter the date on the line at the bottom of this box for *Date Notification Sent*.

What happens if the family changes their mind about the notification?

- If the family initials the line indicating they do not want this information sent to the local school division but later changes their mind, then the service coordinator can either:
  1. Have the parent initial on the second line in this box indicating “I have changed my mind and agree to have this information sent to the local school division.”
  - OR-
  2. Discuss this during an IFSP review meeting, note on page 9 of the IFSP (IFSP Review Record) that the family has decided to allow transmission of this information to the local school division, and have the family sign page 9. If this option is used, then the service coordinator must note in the Notification box on page 7 of the IFSP that the family changed their mind, as indicated on the IFSP Review Record dated \_\_\_\_\_.
- If the family initially leaves the space blank (indicating that they agree to have the information sent), then later decides (prior to it being sent) that they do not want their information sent, they must initial the sentence indicating that they do not want the information sent and include the date they initialed this.
- If a family initials the Notification box indicating they do not want this information sent and later says that they want their child referred to the local school division, there is no need for an IFSP review and no need for the family to indicate they have changed their mind about sending the notification information to the local school division. The notification information is a child find activity, and the family has opted not to have their child’s information sent. When they later decide to have their child referred to the local school division, this is no longer a child find activity and there is no need to go back and change their previous decision not to send the notification information.

- 4) **Transition Planning Requirements** – This section includes a wide range of steps and activities reflecting the variety of possible transition destinations. The transition steps and activities that will be completed for an individual child and family will depend on that family’s specific transition plans and preferences. The steps and activities may be completed in whatever order is most appropriate for each child and family.

The transition pages also are appropriate for use when a child is moving out of the local Part C system’s jurisdiction, either to another local system in Virginia or out of state. If much of the transition page has already been completed based on an expected transition other than the move, then the service coordinator and family may use a new set of transition pages to record the new transition destination and the steps and activities associated with the move. This new set of transition pages must then be attached to the IFSP.

- **Transition Steps/Activities** - All blanks within the table (except “other steps/activities”) must be completed by the time the child transitions. If the child will receive no further services upon leaving early intervention, then non-applicable activities (e.g., sending child referral information to the next setting) should be marked “N/A.” If the family chooses not to complete an activity (e.g., 1b. Arrange visits to programs as desired by the family), then note that in the blank. Please note the following instructions related to specific steps/activities:
  - Steps 2 and 3 – Record the dates that the referral and transition conference actually occur. Other discussions with the family prior to them deciding to accept the offer of a referral or transition conference must be documented either in Step 1d or in contact notes.
  - Step 3b – Verbal approval from the family for the transition planning conference is sufficient. Document the family’s approval/disapproval in a contact note and by checking the appropriate box in activity 3b on the IFSP.
  - Step 4, Activity b – This may include steps to help the child become more familiar with the new program/setting and/or learn new skills needed to adjust to the new program/setting. This may also include steps to assist the family in determining and completing other activities that are needed before the child can move into the new program/setting (e.g., enrollment forms, immunizations, transportation issues, etc.). If these steps require changes in the IFSP outcomes or services, then an IFSP review must be held.
  - Step 5, Activity a – If circumstances required that the Parental Prior Notice form be sent to the family and the form was not returned, then 5a should be marked “No,” and documentation must be available in the child’s record indicating when the form was sent and any follow-up that occurred to obtain a signature.

- Step 5, Activity b – This activity applies only to a children who have been placed on inactive status, in accordance with the no-show flow chart or because they were lost to contact (see Chapter 8), and who have reached the last projected end date for the services listed on their IFSP.
- **Target Date** – Enter the date (month/day/year) by which the step is expected to be completed. It is not necessary to enter target dates for each individual activity.
- **Date Completed** - Enter the date (month/day/year) the corresponding step was actually completed.
- **Initials Person Completing** – Enter the initials of the person who completed the step.

Question: Given the level of detail on page 7 of the IFSP, what needs to go in contact notes related to transition?

Answer: Contact notes should be used to document the following:

- The fact that discussion with the family about transition occurred and that information is documented on page 7 of the IFSP;
- The fact that the service coordinator worked on a transition activity on behalf of the family;
- Communication and planning related to the transition conference (including cancelled meetings with reasons, details about the transition plan that are not documented on Page 7, the names of the people who participated in the meeting, etc).
- Any additional information related to transition that is not documented on page 7 of the IFSP.

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## **PAGE 8:**

### **VIII. IFSP Agreement**

- 1) **Parental Consent for Provision of Early Intervention Services** – This is a statement of agreement with and informed consent for the services as specified in the IFSP. The *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Early Intervention System* must be given to the parent(s) and explained prior to asking them to sign the IFSP. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy.

A contact note must be used to document that another copy of the document was offered and that the family declined.

If the parent expresses disagreement with any portion of this statement, the service coordinator should determine the source of the disagreement and attempt to resolve it with the parent(s). If the parent(s) decide to opt out of one or more services or to opt out of Part C, they must be provided with and sign the *Declining Early Intervention Services* form and their rights must be explained to them.

If this is an initial IFSP, the family will have been provided a copy of *Facts about Family Cost Share* when they initially entered the system. This information should be provided again at each annual IFSP meeting.

- 2) **Parent(s)/Legal Guardian Signature** - Parents sign to affirm their agreement with the consent statement above. Check the appropriate box to indicate whether the signer is the child's Parent, Legal Guardian, or Surrogate Parent.
- 3) **Other IFSP Participants** - Everyone else who participates in the development of the IFSP, in addition to the parent(s), (including anyone accompanying the parents and knowledgeable authorized representatives of anyone directly involved with the eligibility determination and/or assessment for service planning) must sign here and list their role, organization (as applicable), and the full date of signature (month, day, year).
- 4) **The following individuals participated electronically or in writing** - The names of others who participated in the development of the IFSP via phone, internet conferencing, submission of written reports, etc., but were not physically present at the meeting must be entered here. List the specific manner in which each individual participated.
- 5) **Translator/Interpreter (if used)** - List the name and contact number of any individual(s) who either interpreted any portion of the IFSP development process for the family/child, or who was responsible for translating the IFSP into the family's native language.
- 6) **Related documents** – List any related documents that were used to develop the IFSP (for example, medical specialist's evaluation of an aspect of the child's health that is relevant to his developmental progress). These documents, while not part of the IFSP itself, must be included in the child's early intervention record.
- 7) **Copies to** – List here all individuals who will receive a copy of the IFSP. If the IFSP is to be sent to persons who did participate in the eligibility determination, assessment for service planning, or IFSP development and will not be actively involved in carrying out the plan, the parent must sign a separate release of information form. Also, if information is attached to the IFSP that was received from other sources it must be made clear to the

family that their consent to release the IFSP includes the release of the attached report.

- 8) **Physician certification** – This section may be used to document, by physician (or physician assistant or nurse practitioner) signature, medical necessity for services if the child is covered by public (Medicaid or TRICARE) or private health insurance and will receive services that can be reimbursed under that insurance plan. This also serves as the physician order for the medically necessary services listed on the IFSP. A physician's signature, or that of a physician assistant or nurse practitioner, may be obtained on a separate letter referencing the IFSP that is sent with the IFSP or on the *IFSP Summary Letter* instead of on page 6 of the IFSP. Please see the text box in the "Completing the IFSP Form" section of this chapter for specific requirements associated with the physician signature.

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## **PAGE 9:**

**IX. IFSP Review Record** – This page is intended to provide documentation for the IFSP reviews that must be conducted every six months or more frequently as requested by the parent or other team members. The services page and the transition page often require updating during a review. Additions to the IFSP (updates) must be dated and signed. Page 9 of the IFSP documents the parent's consent for any changes to the IFSP made at the time of review.

### Review Required?

**Yes:** An IFSP Review must occur whenever a change to the outcomes, short-term goals or service provision (frequency, intensity, group/individual, method, natural environments/location) specified in the IFSP is being considered.

**No:** An IFSP Review is not required to add or change learning opportunities and activities or modalities or to add/document specific transition strategies. The above additions should be written right on the form and must be initialed and dated. Changes to contact information for the family and/or change in the service coordinator do not require an IFSP review and should be documented on the IFSP as the changes occur.

**No:** An IFSP Review is not required if a short-term goal is not met by the target date. However, it may be appropriate to hold an IFSP review to discuss progress and whether there is a need to change the short-term goal. Otherwise, if the short-term goal is continuing, the team will revise the target date at the next IFSP review. An IFSP review is not needed when a short-term goal is met unless that progress means there is a need to add a new short-term goal(s) or outcome or change a service.

**No:** A review is not required when the frequency, intensity, etc. change if the changes were planned and documented on the IFSP during a prior IFSP meeting (e.g., the team planned and wrote on the IFSP that developmental services would be provided once a week for 3 weeks then change to once every other week).

**No:** A review is not required to change the service provider for an entitled Part C service. If the change is to another provider within the same provider agency selected by the family, then a contact note must document that the family was informed of the change and of their options for informing the service coordinator if a change from the new provider is desired. If a change in provider is necessary or requested by the family and no other provider from the same provider agency is available, then documentation of parent choice of a new provider agency is required on the Addendum page.

**No:** Page 9 of the IFSP does not need to be completed in order to “Close out” an IFSP prior to developing the annual IFSP.

**Other Requirements Associated with IFSP Reviews:**

- *Parental Prior Notice and Confirmation of IFSP Meeting Schedule* procedural safeguard forms must be used prior to an IFSP review. These forms may be mailed ahead of the meeting if necessary (e.g., if the meeting will not be face-to-face and the service coordinator will not see the family before the meeting).
- At a minimum, the review must include the parent(s) and any other friend or family member(s) requested by the parent, the service coordinator, and any direct service provider(s) as appropriate.
- This does not have to be a face-to-face meeting. Any means of reviewing the IFSP that is acceptable to the parents and other participants is permissible, as long as all participants have the opportunity to provide input.
- If the IFSP review is held by means other than a face-to-face meeting, then the contact notes must document the date of the IFSP review. Even though the parent's signature may not be obtained on that date, it is the date the review is held that must be within 6 months of the date the initial or annual IFSP was developed. Contact notes then document efforts to obtain the parent's signature.
- Any new services added at an IFSP review must begin within 30 days of the date the family signs the IFSP Review page unless the team planned a later start date to meet child and family needs.

- 1) **Purpose of Review** – Check the appropriate box to indicate if the review is being held as the required 6-month review of the IFSP or has been specifically requested by the parent or another member of the team.

**Question:** If a service coordinator does a review at 3 months after the IFSP is signed and then again 6 months later (at the 9 month point following the IFSP), does the service coordinator check the 6 month review box at the top of the IFSP review form at the 3 month review or the 9 month review – or both – or never and just checks the “Upon request by \_\_\_\_\_” box for both reviews?

**Answer:** If the IFSP review is being held because it has been about 6 months since the IFSP was developed or reviewed, then check the “6 month review box” on page 9 of the IFSP form. If the review is being held because it was requested by the family or another team member and it is not near the 6-month mark, then check the “Upon request by \_\_\_\_” box. In the example given in the question, the review held at 3 months would be “Upon request by \_\_\_\_\_,” and the review held at 9 months would be marked “6 month review.”



- 2) **Review Date** – Date of the IFSP review meeting. If the IFSP review occurs by phone, then the date of the phone call to review the IFSP is the review date.
- 3) **Summary** – Provide an overview of what was discussed and decided at the review. This should include information from the family regarding their priorities and preferences and information from ongoing assessment in determining which IFSP services are needed. Since information about the child's developmental progress and status is listed here, it is not necessary to complete a new Team Assessment Narrative at an IFSP review. Include the manner in which the review was conducted and any other new information that might affect the IFSP. If there are changes made to the IFSP as a result of this review, include the rationale for the change(s) here.
- 4) **Changes** - Enter any changes that were made to the IFSP as a result of the meeting. This should consist of the current provision and what is changing about it, e.g., Physical Therapy is being changed from 1x/wk. to 1x/mo. If no change is recommended, write "none." Changes authorized here must be entered in the appropriate IFSP section(s), either Section IV - Outcomes, and/or Section V – Services Needed to Achieve Early Intervention Outcomes, by entering the end date for the old provision and writing in the new provision on the next open line/page. If a new outcome is added, the header should retain the original IFSP date and the date the outcome is added should be recorded by "Date Outcome Added." If a new short-term goal is added, include the date it was added when you write or enter the new short-term goal on the outcome page.
- 5) **Projected Start Date for Change** – Record the date the change is projected to begin.
- 6) **Parental Consent** – The parent signs to indicate his/her involvement in the decisions and his/her informed consent for the changes. Parent signature is required even if no changes were made. A written copy of parents' rights must be provided to the parent(s).
- 7) **Other IFSP Participants** - Everyone else who participated in the IFSP review, in addition to the parent(s), (including anyone accompanying the parents and knowledgeable authorized representatives of anyone directly involved in assessment of the child) must sign here and list their role, organization (as applicable), and the full date of signature (month, day, year).
- 8) **The following individuals participated electronically or in writing** - The names of others who participated in the IFSP review via phone, internet conferencing, submission of written reports, etc., but were not physically present at the meeting must be entered here. List the specific manner in which each individual participated.
- 9) **Physician certification** – This section may be used to document, by physician (or physician assistant or nurse practitioner) signature, medical necessity for services if the child is covered by public (Medicaid or TRICARE)

or private health insurance and will receive services that can be reimbursed under that insurance plan. This also serves as the physician order for the medically necessary services listed on the IFSP. A physician's signature, or that of a physician assistant or nurse practitioner, may be obtained on a separate letter referencing the IFSP that is sent with the IFSP or on the *IFSP Summary Letter* instead of on page 6 of the IFSP. Please see the text box in the "Completing the IFSP Form" section of this chapter for other specific requirements associated with the physician signature.

Physician Signature Needed at IFSP Review...

- If the projected end date has been reached and the service will continue? **Yes**
- If a new service is added? **Yes**
- If there is a change (increase or decrease) in frequency or intensity of an existing service? **Yes**
- If a service ends? **No**
- If the child is discharged from Part C? **No**
- If services stay the same but an outcome(s) and/or short term goal(s) changes? **No**
- If the only entitled Part C service listed on the IFSP is service coordination? **No**

Duplicate the page as necessary.

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**ADDENDUM:**

Use this addendum page to document the provider for each entitled service listed on page 6. Generally, the providers are not known at the time of the IFSP meeting so this page may be completed after the IFSP is signed.

- 1) **Entitled Service** – List the entitled services from page 6 of the IFSP, ensuring that each service is listed next to the same number on the Addendum as it is on page 6. This connects the service provider listed in the Addendum with the service details on page 6.
- 2) **Service Provider** – List the service provider's name (e.g., Jane Doe), agency, address and phone number on the top row next to the service. There are 3 rows available for each service in case there is a change in service provider.
- 3) **Current?** – If there is a change in service provider or the service as listed with the corresponding number on page 6 of the IFSP has ended, check the N in this column next to the exiting service provider indicating that this provider is not a current provider. If the service is continuing but there has been a change of provider, then add the name of the new provider on the next row for that same service. Please note the following:
  - An IFSP review is not required in order to change the service provider as long as the service, as listed on page 6 of the IFSP, remains the same.

- If any aspect of the service changes (e.g., the frequency or the intensity), then the service as listed on the IFSP has ended and a new service has started (see page 17, #10). The new service is listed on a new line on page 6 of the IFSP, and that same service must then be listed on the corresponding line of the addendum.
- 4) **Parent Signature** – The parent signs and dates this page to indicate that he/she was given the opportunity to choose from among available provider agencies that work in their local system area and who are in their payor network. All parents must be given this opportunity. In the box called “For Service(s) #” indicate the number (from the list of services on the addendum page) of the service or services to which the signature applies. More information about parent choice of provider is available in the “Selecting Service Providers” section of this chapter.

Some local Infant & Toddler Connection systems are not allowed to remove original documents from the child’s early intervention record once the document has been filed there. If this is the case, it is acceptable to use a new Addendum page to document the service provider and parent choice when a new service is added or when the provider agency changes.

## **ANNUAL IFSP**

(Must be completed within 365 days)

Listed below are page-by-page considerations for the annual IFSP.

### Other Requirements Associated with Annual IFSPs:

- *Parental Prior Notice and Confirmation of IFSP Meeting Schedule* procedural safeguard forms must be used prior to the annual IFSP meeting.
- Prior to developing the annual IFSP, the child's continuing eligibility must be confirmed. This may occur prior to or during the IFSP meeting. The requirements for confirmation of the child's eligibility are specified in the "Annual IFSP" section of Chapter 8.
- At a minimum, the annual IFSP meeting must include the parent(s) and any other friend or family member(s) requested by the parent, the service coordinator, anyone involved in new or ongoing assessment, and any direct service provider(s) as appropriate.
- This must be a face-to-face meeting.
- Any new services added at the annual IFSP must begin within 30 days of the date the family signs the IFSP unless the team planned a later start date to meet child and family needs.

### Page 1

- Fill in the date of the annual IFSP
- Place a check beside "Annual" and note whether this is annual IFSP #1 or #2 (e.g., the annual IFSP done one year after the initial IFSP is annual #1).
- Fill in the date that the six month review is due (after the annual)
- Fill in the dates reviews are completed as they occur

### Page 2

- Complete in the same way as for the initial IFSP. The means of gathering the information may be different since much of it may be gathered through ongoing conversations during intervention sessions and service coordinator visits or calls. This is a great opportunity to assure that the team is staying in sync with the family since child and family routines and the family's priorities, concerns and resources may change over time.

### Page 3

- The providers who are serving the child are expected to be able to make a statement concerning the child's present level of development in each of the developmental areas since ongoing assessment is a routine part of intervention. Re-assessment at the time of the annual IFSP would only be completed if specifically needed in order to complete the:
  - Annual determination of eligibility (see the "Annual IFSP" section of Chapter 8 for steps that must be taken prior to conducting assessment for use in the annual determination of eligibility); or
  - Annual evaluation of the IFSP for an individual child (e.g., the child has recently had major surgery that significantly impacted his/her

developmental status or the child receives services infrequently and no provider has had the opportunity for ongoing assessment for a long period of time).

- Provide an update of the child's overall functioning for the Team Assessment – Narrative.
- Complete the remainder of the page as done for the initial IFSP.

#### **Page 4 and Page 5**

- Begin numbering outcomes with number one (for the service coordination outcome) even if you will be re-writing an ongoing outcome.
- Fill in the target date for the outcomes and the short-term goals. The “date met, changed or ended” will be filled in during future IFSP reviews if/when changes are made to that outcome.

#### **Page 6**

- The only difference for page 6 from the initial IFSP is that some services may already be in progress. These should be listed with “continuing” recorded as the “projected start date.”

#### **Page 7**

- The transition pages from the child's initial IFSP are to follow the child through subsequent IFSPs so that each IFSP includes a complete picture of the transition process. Therefore, the transition pages from the initial IFSP can be either electronically copied into or photocopied and inserted into the annual IFSP. Likewise, the transition pages from the first annual IFSP will be copied and used in the second annual IFSP. The IFSP team will continue adding information on the original transition pages throughout the child's enrollment in Part C. The date of the most current IFSP must be entered at the top of the transition page as it is used in subsequent IFSPs (e.g., the date of the annual IFSP is entered at the top so it is clear that this transition page goes with this annual IFSP).
  - When completing the IFSP electronically, enter the date of the annual IFSP as the IFSP date at the top of page 7.
  - When completing the IFSP by hand, please add the new IFSP date on the second line under IFSP Date at the top of the page without striking through the previous IFSP date (so it does not appear to be an error).

#### **Page 8**

- Complete page 8 as you did for the initial IFSP. The only difference is that the *Facts about Family Cost Share* document must be provided and explained to the family at the time of the annual IFSP.

#### **Page 9**

- Page 9 remains the same as described in the instructions for completion of the initial IFSP.

#### **Addendum**

- Complete the Addendum as you did for the initial IFSP.

## ATTACHMENT A:

### Instructions for Using Word Processing to Customize and to Complete the IFSP Form

#### Making permanent changes to the IFSP form

The IFSP form may be customized with permanent changes for local use **only** in the ways described in the first point under General Information on the first page of these IFSP instructions.

#### **Electronic version of the IFSP:**

When you first open the IFSP form on a word processor, a message may appear asking whether to enable macros. Click yes or *OK*.

**To make permanent changes**, you must first **unprotect** the form. To do this in MS Word:

- Click on the Tools menu
- Click on *unprotect document*

If you will be entering information in a box where you will not need to enter additional information when completing the form for an individual child (e.g., Local System Name), then click on the shaded box, hit *delete*, and then type in the applicable information.

**After you make changes, be sure to protect the document again. If you don't, attempting to type new information will alter the document's format.**

**To protect the document:**

1. Click on the Tools menu
2. Click on *protect document*
3. A window will appear with three options for protecting the document. Select *forms*.
4. The window will also have an option to password protect. If you enter a password, no one will be able to unprotect the document for further permanent changes unless they know that password. If you do not wish to use a password, leave the space blank and click *OK*.

#### **Handwritten version of the IFSP**

This version of the IFSP is not protected. To make permanent changes, click on the shaded box and type in the applicable information. When entering the local system name, you will need to first delete the words "Local System Name Here." Save the document to make these changes permanent, and then print it out for individual completion.

#### Using Word Processing to complete the form

- You will need to make all required and optional changes to the IFSP form before you begin typing an individual child's IFSP. Make sure the document is protected before you begin filling in information of an individual child. If you unprotect the document in the middle of entering a family's information, you will lose the information when you re-protect.

- When filling in the form electronically for an individual child, you must **save the completed IFSP under a different name such as the child's name and date.** This will create a new file and will maintain the blank form. Alternatively, you can save the "original" IFSP form as a template. You will need to name the document when you complete it for an individual child.
- Once protected you will only be able to type in the shaded text boxes. It is advisable to use your tab key to move forward from text box to text box (use shift + tab to move backwards). Your space bar will select and de-select the check boxes on the form.

For local systems that complete the Assessment Narrative in a separate Word document and then paste into the IFSP form

- If pasting the text into the IFSP form results in a page break after the word "Narrative," you can take the following steps to delete the page break:
  - Position the cursor in the first paragraph of the text you pasted in
  - Go to the menu bar at the top of the screen and select *Format*
  - Select *Paragraph*
  - Select the tab that reads *Line and Page Breaks*
  - Unselect the checkbox that reads *Keep with next*
  - Click *OK* and the paragraph will return to the correct page
- Pasting the text in from another document sometimes results in unexpected formatting changes within the pasted text. To prevent this, you need to paste the text without formatting.
  - In order to paste the text, go to the menu bar at the top of the screen and select *Edit*
  - Select *Paste Special*
  - Select *Unformatted Text*
  - Click *OK*

## ATTACHMENT B

### Instructions for Completing the Intellectual Disabilities Targeted Case Management (TCM-ID) Version of the Statewide IFSP Form

The TCM-ID version of the IFSP form requires the following additional or different information from the standard statewide IFSP:

#### Page 1

- **Child's Name** – If the IFSP will be used as the Person Centered Individual Support Plan for Targeted Case Management, then the child's full name must appear on every page. If the child has a nickname, it is acceptable to include that in addition to his/her full name.
- **Dates Quarterly Medicaid Targeted Case Management Reviews Due** – Enter the dates by which the quarterly TCM reviews must be completed. Enter the date the quarter ends, not including the 30-day grace period.
- **Dates IFSP/TCM Reviews Completed** - When the quarterly TCM review is held, write in the date of the review. The quarterly review must reflect the full 90 days of services. Therefore, the review must be completed between the end of the quarter and the end of the 30-day grace period. Although there is no requirement that the quarterly TCM review include the family, local systems are strongly encouraged to consider the quarterly TCM review to be an IFSP review if the IFSP is being used as the Person Centered Individual Support Plan. An IFSP review is required if changes to outcomes or services are being considered.
- **Date(s) Other IFSP Reviews Completed** – When the 6-month or other IFSP review is held separately from a quarterly TCM review, write in the date of the review here. It is not necessary to rewrite the IFSP at every six-month review or when a review is held at a time other than 6 months, as long as the IFSP is updated to reflect the child's current needs and plans. However, a new IFSP form must be initiated at each annual IFSP meeting.
- **Medicaid Number (Optional)** - For children receiving Targeted Case Management Services, it is helpful, though not mandatory to include the child's 12-digit Medicaid number on page 1 of the IFSP. This should be the child's permanent Medicaid number (as opposed to a MCO number, for instance).
- **This IFSP also serves as the Person Centered Individual Support Plan for Targeted Case Management from \_\_\_\_\_ (start date) to \_\_\_\_\_ (end date)** - Check this box if the IFSP is also being used as the TCM Person Centered Individual Support Plan. Enter the start date and end date for the Individual Support Plan. The end date will generally be one year (365 days) from the start date, unless the child is expected to exit Part C sooner than that or the child became eligible for TCM some time after the initial (or annual) IFSP was developed.

#### Page 2

- **Child and Family Activities** – Since targeted case management focuses on the child, it is important that this section clearly identifies activities in which the child participates or the family would like the child to participate as well as the activities the child enjoys.
- **Social Assessment** – In order to meet TCM-ID requirements, provide the child's current status in each of the areas listed. If the required information is covered



either completely or partially in another section of the IFSP, it is acceptable to note next to the appropriate prompt in Section IIc, “See \_\_\_\_\_” or “See also \_\_\_\_\_” rather than repeating the information.

**Reminders:**

Medicaid needs to know if the child has any income. This would include any income in the child’s name, such as trust funds, some child support, etc. This information should be recorded in “Financial, insurance, transportation and other resources.”

In “Physical/mental health, safety and behavior issues,” please note that safety includes any abuse or neglect.

“In Physical/mental health, safety and behavior issues,” list the child’s current medications, both prescribed and over-the-counter (without the exact dosage, as this may change). Somewhere in the child’s record would be a complete list of the current medication; exact dosage; who prescribed; reason; etc. The side effects would be included/attached, usually in that same section of the child’s record. It is not acceptable to simply reference a website for the side effects.

The social assessment must clearly establish the need for targeted case management. It must be clear from the social assessment why the service coordination short-term goals were identified. Identify within the social assessment categories what the family wants help with for their child. The monthly billable case management activities must address the specific needs of the child as addressed in the short-term goals.

If you are using the TCM version of the IFSP for a child who is not eligible for TCM, there is no requirement to complete section IIc, the social assessment. However, it is not acceptable to omit (i.e., delete) section IIc completely from the TCM version of the IFSP. Mark the section N/A or note here that the child is not eligible for TCM. If the information has already been gathered for section IIc (e.g., in the course of assessing eligibility for TCM), then that information should be included in the child’s record.

**Page 3**

- **Eligibility for Targeted Case Management** – Mark whether the child is eligible or not eligible for Intellectual Disabilities Targeted Case Management. In order to be eligible for Intellectual Disabilities Targeted Case Management, the child must be delayed in cognitive and adaptive development. There is no requirement that the delay be of any certain percentage. Please note, however, that adaptive development is defined differently under TCM than under Part C. Under TCM, adaptive skill areas include communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work. Delays in communication, social, and/or adaptive skills would constitute a delay in adaptive development under TCM. In addition, a delay in any other area of development assessed in Part C (except cognitive development, which must be considered separately for TCM eligibility) may

indicate a delay in adaptive skills under TCM if that delay impacts on the areas listed (e.g., self-care, community use, etc.).

- A child under the age of six may also be eligible for Intellectual Disabilities Targeted Case Management due to the presence of a syndrome typically associated with intellectual disabilities.

#### **Page 4**

- **Child will receive...** - Check the appropriate box to indicate whether the child will receive service coordination or service coordination/targeted case management.
- **Outcome (Long-Term Goal)** – Outcome #1 is a general service coordination/case management outcome that is required for all children eligible under Part C.
- **Short-Term Goals** – The short-term goals must be worded in terms of what the service coordinator/case manager will do for the child. For instance, if the social assessment indicates a need for WIC and food stamps, then the short-term goal must make clear that the service coordinator/case manager will “Provide supports identified by your family to include resources for: Meeting John’s nutritional needs by assisting in applying for WIC and food stamps” (or other similar wording). It is not acceptable to write “... resources for: Helping the family get WIC and food stamps.” Similarly, if there is a need to get information or an appointment with a physician, it is not enough to write a short-term goal stating that “the family will follow-up with the physician.”
- **Service Coordinator/Case Manager** – Enter the name, credentials, and role/organization of the individual who will provide service coordination or service coordination/targeted case management.

#### **Page 6**

- **Frequency and Intensity of Service Coordination** - For Part C, direct contact time is with the family and includes activities such as home visits, phone calls and emails with the family, accompanying the family to an appointment, etc. Under Targeted Case Management, direct contact time is with the child. For children receiving TCM, the frequency box must reflect at least one contact directly with the child every 90 days.
- **Actual End Date** – Criteria for Part C eligibility and TCM eligibility are not the same, and children discharged from Part C may still be eligible for TCM. A child who continues to be eligible for TCM once he/she is no longer eligible for Part C cannot be discharged from TCM unless the parent consents. TCM must continue to be provided by someone in the catchment area. Children receiving Targeted Case Management must be given the right to appeal if their TCM services end. If the child is discharged from TCM, an appeal letter must be sent to the family in accordance with requirements in the Medicaid Mental Retardation Community Services Manual, Chapter IV.

#### **Page 8**

- **Other IFSP Participants** – If the case manager is not a Qualified Mental Retardation Professional (QMRP), a supervisor who is must approve the assessment and individual service plan in order to meet licensing requirements (12 VAC 35 – 105-590). The supervisor can sign next to or below the service coordinator/case manager on the IFSP in this situation.

### **Page 9 - TCM**

- The TCM version of the IFSP Review Record page includes prompts for the information required under targeted case management at each quarterly review as well as that required for IFSP reviews under Part C. ***Use of this page is optional.***
  - General Status – Record the child’s general status, including health and safety, at the time of the quarterly review.
  - Significant events – Document any significant events that have occurred since the plan was developed or since the last quarterly review of services.
  - Progress or lack of progress – Describe the progress or lack of progress in meeting the Person Centered Individual Support Plan/IFSP.
  - Satisfaction with services –Describe the family’s satisfaction with services received under the Person Centered Individual Support Plan/IFSP.

### **Page 9**

- The regular version of page 9 is also included with the TCM-ID version of the IFSP. The regular page 9 may be used when an IFSP review is held separately from the quarterly TCM reviews or if the local system decides to document only the Part C requirements on the IFSP (and documents the TCM quarterly review requirements elsewhere).

For additional information about Intellectual Disabilities Targeted Case Management, please see the Mental Retardation Community Services Manual, Chapter IV (available at [www.dmas.virginia.gov](http://www.dmas.virginia.gov), click on Provider Manuals.)

### **Note: Child determined eligible for TCM later**

If a child is not eligible for targeted case management (TCM) at the time of his/her initial Part C eligibility determination and assessment for service planning but later becomes eligible for TCM, the following steps may be taken to use the IFSP as the Person Centered Individual Support Plan for TCM:

1. Hold an IFSP Review to add the required elements of the Person Centered Individual Support Plan (as described above, in this attachment).
2. At the bottom of page 1, enter the start date of the Person Centered Individual Support Plan (which would be the IFSP review date) and enter the end date for the Person Centered Individual Support Plan (which would be one year from the IFSP date, the date the annual IFSP is due).

If the existing IFSP was not developed using the TCM version of the IFSP, then new pages will need to be completed in order to use the IFSP as the Person Centered Individual Support Plan for TCM. The original pages of the IFSP (developed before the child was determined to be eligible for TCM) must not be discarded. Either mark a single line through the old page, initial and date the change and then add the new page or leave the old page as is and add the new page, as page 1a for example.

**Note: MR Waiver**

Some children receiving TCM are also eligible for MR Waiver services. The TCM version of the IFSP has not been designed to meet the additional requirements of the MR Waiver.

## Chapter 8: IFSP Implementation and Review

As children develop and grow and family priorities and concerns change over time, the IFSP changes to reflect new outcomes, supports and services. The service coordinator coordinates and monitors the delivery of IFSP supports and services. The IFSP is reviewed at least every 6 months or whenever a team member, including the family, identifies the possible need for a change. A new IFSP is written annually during the child's enrollment in the Infant & Toddler Connection system. Transition planning and support also occur during this phase of the early intervention process.

### Service Delivery

#### General:

1. The early intervention supports and services listed on the IFSP must begin in a timely manner, within 30 calendar days of the date the parent(s) signs the IFSP. Early intervention supports and services may begin more than 30 calendar days after the parent(s) signs the IFSP if the IFSP team decides on and documents the reasons for a later start date in order to meet the individual needs of the child and family. It is also acceptable to plan a later start date due to family scheduling preference.
  - a. The 30-day timeline applies to new services (i.e., those listed on the initial IFSP and any new services added at an IFSP review or annual IFSP).
  - b. The date of parent signature on the IFSP is day 1 of the 30 calendar days.
  - c. The 30-day timeline begins on the date the parent signs the IFSP regardless of the projected start date listed on the IFSP. In addition, the timely start of services is not related to the frequency with which the service will be provided (e.g., even if the planned frequency of the service is once every two months, that service must begin within 30 days of the date the parent signs the IFSP, unless the team has agreed to a later start date to meet child and family needs or the family prefers to schedule the first visit after 30 days).
  - d. A contact note is required to document the date a service actually begins.
  - e. If the service coordinator participated in the IFSP meeting and/or met with the family on the same day and after the IFSP meeting, then service coordination could be considered as beginning on the date the family signed the IFSP. The service coordinator's signature on the IFSP is adequate to document that the date of parent signature on the IFSP was the start date for service coordination. Other entitled supports and services would begin on the date the parent signs the IFSP only if the service provider delivers an entitled service on that day that is separate from and after the IFSP meeting.
  - f. The 30-day timeline does not apply to delivery of an assistive technology device. The child's early intervention record must include documentation of the steps taken from the date of the signed IFSP to secure the device as quickly as possible.
  - g. Part C early intervention supports and services must be provided only by qualified practitioners. Practitioners, except audiologists, registered dietitians and physicians, who provide early intervention services must be certified by the Department of Behavioral Health and Developmental Services as an Early Intervention Professional, Early Intervention Specialist or Early Intervention Service Coordinator. See Chapter 12 –

Personnel for more information about practitioner qualifications and certification.

2. Families are active participants in each early intervention session. Missed appointments and limited caregiver participation in early intervention sessions are cues that discussion is needed with the family to determine if/why the outcomes or supports and services are not meeting their needs and/or what barriers exist to keeping scheduled appointments or becoming involved in sessions. An IFSP review should be conducted to better align supports and services with family priorities and/or daily activities and routines in order that the Part C early intervention system can be involved in their lives in a way that is helpful to them and that facilitates the parent-provider partnership.
3. In order to establish/maintain rapport and partnership with the family and to determine whether existing supports, services and strategies are working, the service coordinator and other service providers use the following kinds of questions/ideas to begin conversations with families and to guide their listening during visits and other contact with the family:
  - a. How have things been going?
  - b. Tell me about how things are going with breakfast, getting your family out of the house in the morning, etc.
  - c. Tell me about what you and your child did over the weekend.
  - d. Did you have any appointments for your child? Any coming up?
  - e. Tell me about any time of day that's not going well for you with your child.
  - f. In the past week, what time of day has been going well (with or without your child)?
  - g. Have you been able to implement the strategies you practiced at our last session?
  - h. Do you have enough activities to do with your child? Too much?
  - i. How did your child respond to the activities you did with him/her? What worked well? What did not work well?
  - j. Is there anything else I can help you with?
4. Consider what information may be helpful to leave with the family to support them in implementing the activities practiced during the session. Leaving a copy of the contact note or providing pictures or video of particular strategies or positions are potential methods for providing this kind of information to families. The optional state-developed *Early Intervention Activity Note* provides a section for noting suggestions for follow-up during daily routines.

#### Service Coordinator Responsibilities:

1. Coordinate and monitor the delivery of those IFSP supports and services for which the family has given consent.
2. Explain to families who are receiving Part C supports and services that they may receive an annual survey from the State requesting their input on the supports and services they are receiving. Explain that family responses to the survey are confidential and help to improve service delivery in the local area and across the state. Encourage the family to complete the survey when they receive it.
3. Ensure that the language or other mode of communication normally used by the child in the home or learning environment is used in all direct contact with the child, unless clearly not feasible to do so. If the service provider is not able to use the native language and the parent is not able to interpret for the child, then
  - a. A foreign language interpreter must be present. A professional foreign language interpreter is not required. Another IFSP team member may be

able to interpret or there may be an extended family member, neighbor, clergyman, or other family friend who would be willing and able to interpret (if the family agreed). The local Infant & Toddler Connection system may wish to collaborate with the local school system(s) or neighboring early intervention systems in finding foreign language interpreters.

- b. When sign language interpreters are needed, these interpreters must meet professional licensure requirements. To locate qualified sign language interpreters, contact the Virginia Department for the Deaf and Hard of Hearing (1-800-552-7917) or access their website, [www.vddhh.org](http://www.vddhh.org), for a directory of qualified interpreters. If a licensed sign language interpreter is not available in the area served by the local system, then document efforts to locate a licensed sign language interpreter and use a family member, family friend or other informal resource to provide the needed interpreting.
4. Document all contacts made and all activities completed with or on behalf of the child and family in accordance with the requirements specified in Chapter 9.
5. Submit a contact log or contact notes to the local lead agency no later than the 21st of each month for the previous month for all services provided regardless of whether or not Part C funds are being requested.
  - a. Local lead agencies may decide to require all providers to submit only contact logs or only contact notes or may allow each provider the choice of submitting either the log or notes.
  - b. When submitting a contact log, the log must include the type of service delivered (service coordination), date(s) of service delivery, amount of time service was provided on each date, and signature of the provider or an authorized individual from the provider's agency.
6. Ensure that no shows (sessions missed by the family without advanced notice) for services listed on the IFSP are handled in accordance with the procedures given in the flow chart that follows. There are four critical points that local system managers and service providers, including service coordinators, must be aware of when dealing with a no-show situation:
  - a. A no-show situation must be addressed promptly. This protects the child and family in their entitlement to receive supports and services in accordance with the IFSP. It also protects the local system and its available funding;
  - b. The service coordinator plays a very important role in addressing a no-show situation;
  - c. All steps in addressing the situation must be thoroughly documented; and
  - d. A child may only be discharged from the Infant & Toddler Connection system after all of the flow chart steps have been taken and there has been no contact from the family and the projected end dates for all Part C services listed on the IFSP, including service coordination, have been reached.

While implementation of the four points above is required, the timelines provided in the no-show flow chart may be viewed as guidelines. Any monitoring activities associated with the no-show policy will focus on ensuring that the child and family were discharged only under the circumstances listed in the fourth point above and will not focus on whether the exact timelines in the flow chart were met.

# Flow Chart for “No Shows” for Service Visits

## Provider Arrives for Scheduled Visit

### Service Provider Responsibilities

Service Provider (SP) informs Service Coordinator (SC) of each missed appointment **within 2 business days** after the missed appointment (even if SP was able to speak with family within the 2 business days and reschedule appointment)

Then

1. SPs who do not have standing appointments **do not go back out for visits** until the SC or SP is able to contact family.
2. SPs who do have standing appointments must go out for visits as designated on the IFSP

Meanwhile

### Givens

**Documentation of attempts to contact and schedule appointment is critical:**

1. SP's notes reflect contact with SC
2. SC's notes reflect specific attempts to contact family & schedule appointment AND contact(s) with SP

### AND

**Any communication back from the family re-starts the timelines established within this document.**

### Definitions

**Contact** may include, but is not limited to any of the following:

- Telephone call, Home Visit, Fax, E-Mail, Letter, Visit to Place of Employment, etc.

**Inactive:** no additional visits or attempts to contact need to be initiated by local system, but the child is NOT discharged

### Service Coordinator Responsibilities

SC makes initial attempt to contact family within **2 business days of notification by service provider** (if SP was unable to contact family).

#### Purpose of Contact

1. Find out reasons for missed appointments
2. Determine need for IFSP review, and
3. Coordinate scheduling next visit for other service providers

Then

SC has **3 additional business days** to make an **additional two attempts** to contact the family. If 2 attempts are by phone & no voice message is left, the third attempt **MUST** be either by regular US mail or home visit.

Then

If there has been no response from family within **7 calendar days of the third attempt** to contact, then on the next business day the SC sends **a letter** (*certified letter recommended but not required*).

#### Content of letter

1. Information letting the family know about missed appointment(s)
2. Attempts to contact
3. Services are still available
4. Can do IFSP review
5. Please contact Service Coordinator to schedule review and/or next service appointment

Then

If there has been no contact initiated by the family **within 10 calendar days of sending letter**, SC notifies SP, in writing, that status of the case is “inactive” until communication is made with family or projected end date for entitled services, including Service Coordination.

Targeted Case Management **MUST** close case to Medicaid but leaves case open to Part C on “inactive” status.

Then

On **projected end date for entitled services**, Parental Prior Notice is sent to family with a copy in child's record.

#### Top Section:

- Check “Other” (Your child is being discharged from the Part C system)

#### “Reason” Section:

- **MUST** summarize all attempts to contact family **AND** list end date for entitled services listed on IFSP.



7. Complete the following steps if a child and family are lost to contact (without a no-show):
  - b. Contact the referral source, physician or other contacts to request additional or updated contact information;
  - c. If still unable to contact a family after requesting additional contact information or the family repeatedly fails to respond, then document the dates of attempted contact in the child's record. Attempts to contact the family may be made by phone, mail, visiting the address provided, and/or other means based on the contact information available. It is recommended that no more than 15 – 20 calendar days pass during this process of attempting to contact the family;
  - d. Send a letter to the family notifying them of the attempts to contact them, the services that are still available to them, the opportunity for an IFSP review if an IFSP has been developed, and the need for them to contact their service coordinator;
  - e. If no contact has been made by the family within 10 calendar days of sending the letter, then place the child on inactive status.

The child may only be discharged from the Infant & Toddler Connection system after all of the above steps have been taken and there has been no contact from the family and (if there is a signed IFSP in place) the projected end dates for all Part C services listed on the IFSP, including service coordination, have been reached.

8. If a child is determined to be inactive, then enter required data on the ITOTS Discharge/Inactive Tab within 10 business days of the child becoming inactive. If the child later returns to active status, enter that data on the ITOTS Discharge/Inactive tab within 10 business days of the child becoming active. [See ITOTS instructions at <http://www.infantva.org/documents/forms/INST1117eR.pdf>]
9. Offer to hold an IFSP review if a family indicates they wish to decline all services after having started services. Explain to the family that the purpose of the IFSP review meeting would be to:
  - b. Discuss the outcomes, supports and services and whether the family would like changes in the current supports and services instead of ending all services; and/or
  - c. Make a determination of child progress on the child indicators if the child has been receiving services for at least 6 months. If the family wants to end services immediately and declines to participate in a determination of child progress, then that decision must be documented in a contact note. See the "Discharge and Determination of Child Progress at Exit" section later in this chapter for additional information on determining child indicator ratings at exit.
10. Follow-up on any child who no longer has Medicaid/FAMIS coverage by checking with the family to determine if they are in the process of re-applying or if the child no longer meets the Medicaid/FAMIS financial eligibility requirements.
  - a. Approximately 20% of the Medicaid population loses their benefit for a variety of reasons, including failure to complete the re-application process. If the family is in the process of re-applying, then the service coordinator should:
    - Connect with the local Department of Social Services Office so the child's eligibility worker can assist the family with completion of the steps necessary to restore the benefit;
    - Contact the family weekly until the coverage is restored and notify the local system manager when the benefits are restored; and
    - Obtain information about the status of the application from the child's eligibility worker (DSS), if needed.

- b. If the child is no longer financially eligible, the service coordinator must update the *Family Cost Share Agreement* form with the family, and the Medicaid/FAMIS information must be deleted in ITOTS.
- c. If the child's Medicaid/FAMIS coverage is not restored within 60 days of the date coverage ended, the Medicaid/FAMIS information must be deleted in ITOTS. If Medicaid/FAMIS coverage is later restored, Medicaid/FAMIS must be selected in ITOTS and the 12 digit number re-entered.

Responsibilities of Other Early Intervention Service Providers:

1. Schedule the initial service session within 30 days of the date the family signs the IFSP unless the team has planned a later start date to meet child and family needs. Document in contact notes all attempts to schedule and deliver services, being especially careful to specify all circumstances resulting in a delay in holding the first visit with the child and family.
2. Deliver services in accordance with the IFSP. When a provider cancels a visit, that visit must be rescheduled as soon as possible to ensure that the service is delivered at the frequency and intensity listed on the IFSP.
  - a. It is not necessary to make up sessions missed because the family cancels.
  - b. Sessions cancelled by the provider and sessions that fall on holidays must be made up, unless the family states that they do not wish to make up the missed session (contact notes must document the offer to reschedule and the fact that the family declined this offer).
  - c. If the provider is unable to make up the session her/himself, every attempt should be made to schedule a make-up session with a therapist from the same agency so the service is still authorized and provided by a practitioner within the child/family's insurance network. If there is not a provider in that agency, the substitute provider should be selected from among those participating in the child/family's insurance network if possible; and, if necessary, pre-authorization must be obtained.
  - d. Missed sessions may be made up by scheduling a new, full session or by adding time to other sessions (e.g., if a 45-minute session is missed, a new 45-minute session may be added or 15 minutes could be added to each of the next 3 sessions). The determination of how best to make up the time missed in a previous session must be based on what is best for and meets the needs of the child and family.
  - e. Contact notes must document efforts to reschedule missed sessions and must clearly document when a session is a make-up from a missed visit or when it is extended in order to make up a previously missed visit.
3. Conduct ongoing assessment as part of service delivery. Service providers observe the child's functioning and skills across all developmental domains as a routine part of service delivery. When needed, the service provider may use an assessment tool as a reference point especially for areas of development outside his/her area of expertise. This still occurs as a part of the provider's interactions with the child during service delivery and is not a separate activity. Ongoing assessment gives the provider information not only on the child's progress on the outcomes and short-term goals being addressed by the current activities but also helps the provider identify any emerging concerns in other areas of development.
4. Work as a team member to support the child and family in achieving the IFSP outcomes. Team members consult and team with each other and with the family to ensure that services are coordinated and consistent with one another and support functional development of the child as a whole. This is true whether multiple providers are visiting

the family or there is a primary provider. If the IFSP team determines that one primary provider will work with the family, then other team members support the primary provider and the child and family by providing consultation to the primary provider, participating in joint visits with the primary provider to the child and family, and/or suggesting strategies and techniques to enhance progress toward outcomes.

5. Schedule visits during the family's everyday routines and activities.
6. Use items already present in the child's environment when providing early intervention supports and services. This assists the family/caregiver to identify what they have in their own environment that can be used during daily routines and activities to accomplish the outcomes.
7. Focus interaction with the child and family on expanding the family's confidence and competence to help the child learn and develop during everyday activities by:
  - a. Modeling strategies during the routine for the family;
  - b. Coaching the family as they try out the strategies for themselves; and
  - c. Checking with the family before the visit ends to ensure the family understands the strategies and can implement them during their routines.
8. Continually consider what support the family or other caregiver needs in order to implement strategies within their child's and family's daily routines and activities.
9. Monitor, in partnership with the family, the effectiveness of strategies used and the appropriateness of service frequency and intensity.
10. Contact the service coordinator to request an IFSP review when there is a need to discuss potential changes to outcomes or services or if the child may now be at age level and demonstrating typical development. Specific recommendations to the family about potential changes to outcomes and/or services should be discussed during the IFSP review.
11. Contact the service coordinator when there are missed appointments or other difficulties with parent participation.
12. Routinely (at least once a month) confirm with families whether or not their insurance has changed. Notify the local system manager immediately if a child who has or had Medicaid/FAMIS no longer has Medicaid/FAMIS or does not have the Medicaid EI benefit, and notify the service coordinator if the child had TRICARE or private insurance coverage and the child no longer has that coverage. For children with Medicaid, the following specific procedures apply. The Medicaid Early Intervention Services Manual, Chapter 3, states that eligibility for Medicaid benefits must be confirmed each time a service is rendered. While it is the provider's responsibility to verify Medicaid eligibility prior to every visit, changes in Medicaid eligibility tend to occur at the beginning or end of the month. An effective strategy is to verify Medicaid eligibility the first week of the month and after the 20<sup>th</sup> of the month. The provider must:
  - a. Contact the Part C Office if the Medicaid EI benefit is not added within a week; and
  - b. Retain documentation of all contacts with the Local System Manager and with the Part C Office as these will be used to determine the start date for adding (back) the Medicaid EI benefit.

Options for verifying a child's Medicaid/FAMIS coverage are discussed in the "Family Cost Share Practices" section of Chapter 11 (see the text box titled "Medicaid/FAMIS and Medicaid EI Benefit Eligibility Verification").

13. Document all contacts made and all activities completed with or on behalf of the child and family in accordance with the requirements specified in Chapter 9.
14. Submit a contact log or contact notes to the local lead agency no later than the 21st of each month for the previous month for all services delivered, regardless of whether or not Part C funds are being requested.

- a. Local lead agencies may decide to require all providers to submit only contact logs or only contact notes or may allow each provider the choice of submitting either the log or notes.
- b. When submitting a contact log, the log must include the type of service delivered (e.g., physical therapy, developmental services, OT, etc.), date(s) of service delivery, amount of time service was provided on each date, and signature of the provider or an authorized individual from the provider's agency.
- c. When insurance reimbursement is pending for a service, include that service on the log for the month in which the service was delivered and mark it "insurance pending." Once the insurance company has acted, if Part C funds are being requested, then submit that service again on a later log for payment by Part C.

## IFSP Reviews

### General:

1. The purpose of the periodic IFSP review is to determine the degree to which progress toward achieving the outcomes is being made and whether modification or revision of the outcomes or supports and services, including frequency and intensity, is necessary.
2. An IFSP Review must occur whenever a change to the outcomes, short-term goals or service provision (frequency, intensity, group/individual, method, natural environments/location) specified in the IFSP is being considered. More information about when an IFSP review is required is available in the IFSP Instructions at the end of Chapter 7 (see instructions for completing page 9 of the IFSP form).
3. If the family or another IFSP team member(s) believes the child has reached age level in all areas of development and shows no sign of atypical development, then an IFSP review is held to determine eligibility. Eligibility determination can occur during the IFSP review meeting (as long as 2 disciplines participate).
  - a. Ongoing assessment should document the child's functional status across settings and situations before a provider considers that the child's development is typical and at age level compared to same-age peers.
  - b. If at any time the family feels their child is demonstrating age-appropriate skills and is no longer in need of services, the service coordinator must offer to coordinate an eligibility determination to confirm the child's status. However, if the family declines this offer, then the service coordinator must document both the offer and the family's decision in a contact note and the eligibility determination is not held. When reporting in ITOTS the reason for discharge in this scenario, please use "Completion of IFSP prior to reaching age 3."
  - c. The determination of ongoing eligibility is based on progress reports (written or verbal, based on contact notes) of team members and/or review of contact notes, considers all areas of development, and is documented on the *Eligibility Determination Form* (see the "Determining Eligibility" section of Chapter 5 for instructions on completing this form). The service coordinator provides the family with a copy of the completed *Eligibility Determination Form*.
  - d. A multidisciplinary team is required for determination of ongoing eligibility, even for children who were previously found eligible based on a diagnosed condition. Therefore, if, for example, the child is receiving only service coordination and occupational therapy or the child is only receiving service coordination, then it will be necessary to pull in a second discipline to participate with the occupational therapist and the service coordinator or to pull in 2 disciplines to participate with the service coordinator in the determination of ongoing eligibility. If a child is receiving only service coordination, then the same types of information that are gathered for initial eligibility determination would be gathered for this interim

confirmation of eligibility (e.g., current developmental screening results, observation, parent report, current information from the physician, etc.). The service coordinator, if properly trained, can conduct the developmental screening and observation and gather information from the parent.

- e. The information gathered for determining eligibility may also assist the team in completing the exit ratings on the child indicators for those children found to be no longer eligible and who have been in the Infant & Toddler Connection of Virginia system for at least 6 months since their initial IFSP. See the “Discharge and Determination of Child Progress at Exit” section of this chapter for additional information on exit assessment.
  - f. It is only necessary to determine the child’s eligibility prior to discharge if the local system is proposing to end services prior to the child’s third birthday. Eligibility determination is not necessary prior to discharge if the child is leaving the local system for any of the following reasons: the child is turning three, the child is transitioning to Part B, the family is moving out of the area served by the local system, the child and family are lost to contact, or the parent declines continued services.
4. Families and other IFSP team members can request an IFSP review at any time by contacting the service coordinator.
  5. The IFSP review may be carried out by a meeting or by another means that is acceptable to the parents and other participants as long as all IFSP team members have the opportunity to provide input about all contents of the IFSP.
  6. Any new services added at an IFSP review must begin within 30 days of the date the family signs the IFSP Review page unless the team planned a later start date to meet child and family needs.

#### A Question about Adding New Services

**Question:** Prior to adding a new service is it necessary to have an assessment completed by that discipline (e.g., if the team wants to add occupational therapy, is an OT assessment required before adding that service)?

**Answer:** Neither the Part C Office nor Medicaid requires an assessment when services by new disciplines are added to the child’s IFSP. However, providers must be aware of their discipline’s licensure requirements. For example, physical therapists must evaluate (assess, in Part C terms) a client prior to providing services. When a new service is added to the IFSP, the provider will need to use his/her discipline-specific expertise to determine what strategies are needed to address the outcomes determined by the team. This type of assessment will occur during the first session(s) with the child and family. This session(s) should be documented in a contact note, just as ongoing assessments are documented. The provider may or may not determine that additional outcomes or short term goals are needed (in which case an IFSP review will be needed).

#### Service Coordinator Responsibilities:

1. Facilitate the periodic review of the IFSP at least every six months or more frequently if conditions warrant or the family requests a review.

- a. If a review is conducted before 6 months, then the 6-month review timeline may be re-started at that point. For example, if the initial IFSP is developed on 6/30/09 and an IFSP review is conducted on 10/15/09 because the family requests consideration of a change in service frequency, then the next IFSP review must be conducted by 4/15/10. Local systems are not required to use a moving 6-month review date as illustrated in the example. It is acceptable to keep the 6-month review date fixed at 6 months from the date of the initial IFSP regardless of whether interim reviews are held.
  - b. The due date for the annual IFSP does not change regardless of when IFSP reviews are held. The annual IFSP must be held within 365 days of the date of the initial or previous annual IFSP.
2. Ensure the family receives a copy and explanation of the *Parental Prior Notice* form (with a check mark by "A meeting to revise or review the IFSP is needed"), *Confirmation of the Individualized Family Service Plan (IFSP) Schedule* form, and *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*. Review the purpose of the IFSP review, the family's role in the review process, and the safeguards applicable to this step in the early intervention process. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
3. Assist the family in preparing for the IFSP review. Share any written information from providers about the child's progress with the family prior to the IFSP review, if available. Encourage families to make notes of their input and questions prior to the IFSP review. The level of support that each family will want and need in preparing for the IFSP review will vary and should be individualized for each family.
4. Assist the family in identifying IFSP review participants. The following participants are required:
  - a. The parent(s) of the child;
  - b. Other family members, as requested by the parent, if feasible;
  - c. An advocate or person outside the family if requested by the parent; and
  - d. The service coordinator who has been working with the family;
  - e. A person or persons involved in ongoing or new assessments and individuals who are providing supports and services to the child and family participate as needed.
5. Work with the family and other participants to determine a process for reviewing and revising the IFSP that is acceptable to all parties and allows for all participants to provide input. A face-to-face meeting is not required for an IFSP review. The method used to conduct the IFSP review should ensure the following:
  - a. The family has the information and support they need to make informed decisions for their child and family;
  - b. The family's current priorities and concerns are reviewed; and
  - c. All participants have a current and complete picture of the degree to which progress toward meeting the outcomes is being made.
6. Ensure that the meeting is conducted in the family's native language or other mode of communication unless clearly not feasible to do so.
7. Complete the appropriate sections of the statewide IFSP form (see IFSP instructions at the end of Chapter 7).
8. Ensure the family's signature is obtained on the IFSP review page to document their consent for the changes, if any. Even if there are no changes, the family still signs the

IFSP review page. If new services are being added at the IFSP review, the family must be offered the opportunity to select a service provider and must sign the addendum page indicating they were given this opportunity.

9. Retain a signed copy of the IFSP with the review page and provide a copy to the family and to all service providers who participated in assessment or the IFSP review or will be implementing the IFSP. The parental consent statement that the family signs on the IFSP gives consent for the IFSP to be shared with these providers.
10. Obtain physician (or physician assistant or nurse practitioner) signature to document medical necessity for services if the child will receive services that can be reimbursed under public (e.g., Medicaid, TRICARE) or private insurance. The physician's signature may be obtained on one of the following:
  - a. The IFSP; or
  - b. A separate letter referencing the IFSP that is sent along with the IFSP; or
  - c. The *IFSP Summary Letter*.

This documentation also serves as the physician order for the medically necessary services listed on the IFSP. Please see the text box in the "Completing the IFSP Form" section of Chapter 7 for specific requirements associated with the physician signature.

11. Ensure that if the family declines one or more early intervention services listed on the IFSP (but not all services listed on the IFSP), then the following steps occur:
  - a. Obtain the family's signature on the *Declining Early Intervention Services* form and provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*. Using the top half of the *Declining Early Intervention Services* form, fill in the date of the IFSP and the service(s) the family is declining. Both the service coordinator and family must sign and date the form.
  - b. Explain that the services that are not declined will be provided at the frequency, intensity and duration listed on the IFSP.
  - c. In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
  - d. Explain how the family may, at a later date, through the IFSP review process, accept a service previously declined.
12. Ensure that if the family declines all services listed on the IFSP, then the following steps occur:
  - a. Obtain the family's signature on the *Declining Early Intervention Services* form and provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*.
    - Using the bottom half of the *Declining Early Intervention Services* form, the family is asked to mark the third line (that their child is eligible and has the right to receive the services listed on the IFSP and that they do not choose to have their child receive services through the Infant & Toddler Connection system).
    - Explain to the family how they can contact the local Infant & Toddler Connection system in the future using the phone number provided at the bottom of the form if they have concerns about their child's development.

- In explaining the Notice of Child and Family Rights and Safeguards, the service coordinator reviews and explains the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
  - b. If the child is close to being age eligible for early childhood special education services through the local school division (under Part B), explain how to access Part B services through the local school division.
  - c. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.
  - d. Communicate the child's exit from Part C services to the primary care physician and primary referral source (if appropriate), with parent consent.
  - e. Enter the date of closure in ITOTS within 10 business days of the family declining all services and indicate in the discharge/transition destination section that the parent withdrew.
13. Ensure that if the family is requesting a specific early intervention service, or a specific frequency, intensity, location or method of delivering services that the rest of the team does not agree is appropriate to meet the needs of the child or family, then the following steps occur:
- a. Provide a copy and explanation of the *Parental Prior Notice* form to the family. The "Other" line is checked and refusal to initiate the specific service is written in as the description. The reason why the Infant & Toddler Connection system is refusing to initiate the service is specified (e.g., progress made, other supports and services in place, evidence-based practice, etc.). If there is not enough space on the form to describe the reason for refusing to initiate the service, then additional documentation may be attached to the form and referenced in the "Reason" section of the form. Parent signature is obtained to acknowledge receipt of the form.
  - b. Provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System* to the family. In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
  - c. For Medicaid recipients only: Complete and provide the family with the *Early Intervention Services – Notice of Action* letter and explain to the family their right to appeal under Medicaid if they disagree with the early intervention services listed on the IFSP. Point out where additional information about the appeal process is located in the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*.

Completion of these steps protects both the family and the local system, ensuring that the family understands their rights, safeguards and opportunities for addressing the disagreement if they so choose and that local systems have clear documentation of the service requested and reasons for refusing to initiate that service.



14. Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.

Responsibilities of Other Early Intervention Service Providers:

1. Provide information to the family and other team members on the child's progress based on ongoing assessment.
2. Participate in the IFSP review through the methods determined by the team, which may include a face-to-face meeting or sharing information by phone or in writing.
3. Consider the family's current priorities and concerns when making recommendations or participating in team decisions about changes to outcomes and/or supports and services.
4. Limit the use of jargon and acronyms and explain words or concepts that may be unfamiliar to the family.

Annual IFSP

Service Coordinator Responsibilities:

1. Conduct, in person, an annual IFSP meeting within 365 days of the date of the initial or previous annual IFSP meeting to review the child's progress and to write a new IFSP if the child continues to be eligible. If a child moves from one local early intervention system within Virginia to another, the child's annual IFSP date is based on the child's initial IFSP date (or previous annual IFSP date) regardless of the child's location for the previous IFSP (e.g., if child had an initial IFSP developed on 10/12/08 in one local system, then moved to a new local system on 4/1/09, then the annual IFSP still must be developed by 10/12/09).
2. Ensure the family receives a copy and explanation of the *Parental Prior Notice* form (with a check mark by "A meeting to develop the annual IFSP and confirm eligibility is needed"), *Confirmation of the Individualized Family Service Plan (IFSP) Schedule* form, and *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
3. Notify other team members in writing of the date, time and location of the annual IFSP meeting. Other team members may be notified using the same form used to notify the family, the *Confirmation of the Individualized Family Service Plan (IFSP) Schedule* form, or through other written means (e.g., email). Documentation must be maintained in the child's early intervention record that shows that the family and other team members were notified in writing in advance of the IFSP meeting.
4. Explain that the annual IFSP meeting will include a confirmation of ongoing eligibility, regardless of the reason for initial eligibility (i.e., even for children with a diagnosed condition), and that if the child no longer meets the Infant & Toddler Connection of Virginia eligibility criteria then he/she will be discharged.
  - a. The annual confirmation of ongoing eligibility is based on progress reports (written or verbal, based on contact notes) of team members and/or review of contact notes, considers all areas of development, and is documented on the *Eligibility Determination* form (see the "Determining Eligibility" section of Chapter

5 for instructions on completing this form). The service coordinator provides the family with a copy of the completed *Eligibility Determination Form*.

- b. Use of the Virginia Part C Vision and Hearing Screening tools are not required for the annual confirmation of eligibility. Providers should be alert to any signs that the child may be experiencing difficulty with hearing or vision, as such issues can arise at any age. In such cases, administration of the Hearing or Vision Screening tool would be appropriate.
- c. The confirmation of ongoing eligibility may occur prior to or during the annual IFSP meeting.
- d. A multidisciplinary team is required for determination of ongoing eligibility. Therefore, if, for example, the child is receiving only service coordination and occupational therapy or the child is only receiving service coordination, then it will be necessary to pull in a second discipline to participate with the occupational therapist and the service coordinator or to pull in 2 disciplines to participate with the service coordinator in the determination of ongoing eligibility.
- e. If, at the time of the annual IFSP, the family feels their child is demonstrating age-appropriate skills and is no longer in need of services and the family does not want to have an eligibility determination to confirm the child's status, then the service coordinator must document both the offer and the family's decision in a contact note. When reporting in ITOTS the reason for discharge in this scenario, please use "Completion of IFSP prior to reaching age 3."

#### Annual Eligibility Determination Scenarios:

1. A child is receiving service coordination only and was initially found eligible based on a diagnosed disabling condition.  
Two disciplines must participate in the annual determination of eligibility regardless of the initial reason for eligibility. In this scenario, they will be able to quickly review documentation of the child's diagnosed condition in order to confirm his ongoing eligibility.
2. A child is receiving service coordination only and it is unknown whether the child continues to meet eligibility criteria based on developmental delay or atypical development.  
The service coordinator (if trained to conduct screenings) or another provider will complete a developmental screening. The service coordinator will then compile up-to-date health and developmental information (including screening results, parent report, and information from observation) for the multidisciplinary eligibility determination team to review. As with the initial determination of eligibility, if the available health and developmental information is insufficient to confirm the child's eligibility, then the team may request targeted assessment to gather the additional information needed.
3. A child is receiving service coordination and occupational therapy, but continued eligibility is unknown due to child progress.  
The OT and one other discipline review existing information based on ongoing assessment (progress reports, contact notes) and determine the child's eligibility. In the rare situation when the team needs more information, targeted assessment is done to gather the additional information needed to determine continued eligibility.
4. A child is receiving service coordination and developmental services and his continued eligibility can be determined through the use of progress notes and informal assessment by the current service provider.  
The educator and one other discipline review existing information based on ongoing assessment (progress reports, contact notes) and determine the child's eligibility.
5. A child will be turning 3 within 6 months and an exit assessment (formal or informal) by an Early Intervention Professional is needed in order to determine the child's progress on the 3 child indicators.  
The information gathered for the exit assessment can also be used to confirm the child's continued eligibility. It would make sense for the provider that is completing a tool (based on ongoing assessment) for the exit assessment to participate in the eligibility determination along with one other discipline.

**If the child is ineligible:**

- a. Provide the parents with a copy and explanation of the *Parental Prior Notice* form (indicating “Your child is not eligible for Infant & Toddler Connection of Virginia”) and the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*. On the *Parental Prior Notice* form, identify the information used to make the determination that the child is not eligible. In explaining the Notice of Child and Family Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
- b. For Medicaid recipients only: Complete and provide the family with the *Early Intervention Services – Notice of Action* letter and explain to the family their right to appeal under Medicaid if they disagree with the multidisciplinary team’s determination that their child is no longer eligible for early intervention services. Point out where additional information about the appeal process is located in the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*.
- c. Provide the family with a copy of the completed *Eligibility Determination Form*.
- d. Facilitate an opportunity for the family to talk with the eligibility determination team if the family has questions or disagrees with the eligibility finding and if desired by the family.
- e. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.

**If the child continues to be eligible, proceed with the steps below.**

5. Assist the family in planning and preparing for the annual IFSP meeting. Encourage families to make notes of their input and questions in each section of their current IFSP or a blank IFSP form and to bring that to the IFSP meeting as a reminder for the family during the meeting. The level of support that each family will want and need in preparing for the annual IFSP meeting will vary and should be individualized for each family.
6. Assist the family in identifying participants for the annual IFSP meeting. The following participants are required:
  - a. The parent(s) of the child;
  - b. Other family members, as requested by the parent, if feasible;
  - c. An advocate or person outside the family if requested by the parent;
  - d. The service coordinator who has been working with the family;
  - e. A person or persons involved in ongoing or new assessments; and
  - f. As appropriate, individuals who are providing supports and services to the child and family.
7. Arrange IFSP meetings in the setting and language that facilitate a family's ability to participate.
8. Notify all participants in writing of the date, time and location for the IFSP meeting:
  - a. Parents must be notified using the *Confirmation of Individualized Family Service Plan (IFSP) Schedule* form.
  - b. Other team members may be notified using that same form or through other written means (e.g., email).
  - c. Documentation must be maintained in the child’s early intervention record that shows that the family and other team members were notified in writing in advance of the IFSP meeting.

9. Ensure that IFSP team members who are not able to meet at times convenient for the family are given other options for IFSP participation, such as telephone consultations or providing written information.
10. Provide the family with a copy and explanation of *Facts About Family Cost Share* and obtain their signature on a new *Family Cost Share Agreement* form. Please see the “Family Cost Share Practices” section of Chapter 11 for steps to take if the family does not sign the new agreement form promptly.
11. Facilitate determination of interim assessments/ratings of child progress using the procedures described in the Discharge section of this chapter for the exit rating, if the local Infant & Toddler Connection system chooses to do interim ratings.
12. Ensure a new IFSP is developed using the statewide IFSP form and the IFSP Instructions that are found at the end of Chapter 7.
13. Ensure the family’s signature is obtained on the IFSP to document their consent for the services.
14. Retain a signed copy of the IFSP and provide copies to the family and to all service providers who participated in assessment or development of the IFSP or will be implementing the IFSP. The parental consent statement that the family signs on the IFSP gives consent for the IFSP to be shared with these providers.
15. Send a copy of the IFSP to the child’s primary care physician, with parent consent. Consent to send a copy of the IFSP to the physician is not covered by the consent statement on the IFSP and requires a separate release of information form.
16. Obtain physician (or physician assistant or nurse practitioner) signature to document medical necessity for services if the child will receive services that can be reimbursed under public (e.g., Medicaid or TRICARE) or private insurance. The physician’s signature may be obtained on one of the following:
  - a. The IFSP; or
  - b. A separate letter referencing the IFSP that is sent along with the IFSP; or
  - c. The *IFSP Summary Letter*.

This documentation also serves as the physician order for the medically necessary services listed on the IFSP. Please see the text box in the “Completing the IFSP Form” section of Chapter 7 for specific requirements associated with the physician signature.

17. Ensure that if the family declines one or more early intervention services listed on the IFSP (but not all services listed on the IFSP), then the following steps occur:
  - a. Obtain the family’s signature on the *Declining Early Intervention Services* form and provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*. Using the top half of the *Declining Early Intervention Services* form, fill in the date of the IFSP and the service(s) the family is declining. Both the service coordinator and family must sign and date the form.
  - b. In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
  - c. Explain how the family may, at a later date, through the IFSP review process, accept a service previously declined.
18. Ensure that if the family declines all services listed on the IFSP, then the following steps occur:

- a. Obtain the family's signature on the *Declining Early Intervention Services* form and provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*.
    - Using the bottom half of the *Declining Early Intervention Services* form, the family is asked to mark the third line (that their child is eligible and has the right to receive the services listed on the IFSP and that they do not choose to have their child receive services through the Infant & Toddler Connection system).
    - Explain to the family how they can contact the local Infant & Toddler Connection system in the future using the phone number provided at the bottom of the form if they have concerns about their child's development.
    - In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
  - b. If the child is close to being age eligible for early childhood special education services through the local school division (under Part B), explain how to access Part B services through the local school system.
  - c. Obtain parent consent to make referrals to other appropriate resources/services based on child and family needs and preferences.
  - d. Communicate the child's exit from Part C services to the primary care physician and primary referral source (if appropriate), with parent consent.
  - e. Enter the date of closure in ITOTS within 10 business days of the family declining all services and indicate in the discharge/transition destination section that the parent withdrew.
19. Ensure that if the family is requesting a specific early intervention service, or a specific frequency, intensity, location or method of delivering services that the rest of the team does not agree is appropriate to meet the needs of the child or family, then the following steps occur:
- a. Provide a copy and explanation of the *Parental Prior Notice* form to the family. The "Other" line is checked and refusal to initiate the specific service is written in as the description. The reason why the Infant & Toddler Connection system is refusing to initiate the service is specified (e.g., progress made, other supports and services in place, evidence-based practice, etc.). If there is not enough space on the form to describe the reason for refusing to initiate the service, then additional documentation may be attached to the form and referenced in the "Reason" section of the form. Parent signature is obtained to acknowledge receipt of the form.
  - b. Provide a copy and explanation of the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System* to the family. In explaining the Notice of Child and Family Rights and Safeguards, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note

must be used to document that another copy of the document was offered and that the family declined.

- c. For Medicaid recipients only: Complete and provide the family with the *Early Intervention Services – Notice of Action* letter and explain to the family their right to appeal under Medicaid if they disagree with the multidisciplinary team's determination that their child is not eligible for early intervention services. Point out where additional information about the appeal process is located in the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*.

Completion of these steps protects both the family and the local system, ensuring that the family understands their rights, safeguards and opportunities for addressing the disagreement if they so choose and that local systems have clear documentation of the service requested and reasons for refusing to initiate that service

20. Ensure that copies and explanations of procedural safeguard forms are provided in the family's native language or other mode of communication unless clearly not feasible to do so.

#### Responsibilities of Other Early Intervention Service Providers:

1. Provide information to the family and other team members on the child's progress based on ongoing assessment for use in determining the child's ongoing eligibility and, if the child remains eligible, for use in developing the annual IFSP.
2. Participate in the annual IFSP meeting. This applies to service providers who were part of new or ongoing assessment and, as appropriate, providers who are providing supports and services to the child and family. Service providers who are not able to participate in the meeting in person may participate through other options, such as telephone consultations or providing written information.
3. Consider the family's current priorities and concerns when making recommendations or participating in team decisions about outcomes and/or supports and services. Additional considerations are detailed in Chapter 7 under "Responsibilities of Other Early Intervention Service Providers."
4. Limit the use of jargon and acronyms and explain words or concepts that may be unfamiliar to the family.

#### Transition

##### Service Coordinator Responsibilities:

1. General Transition Steps and Services
  - a. Ensure that each child and family is offered individualized transition supports and services.
  - b. Ensure that individualized transition planning activities are documented on the child's IFSP.
  - c. Ensure the referral and timely transfer and exchange of records and other information for families who:
    - Enter into the early intervention system from hospitals, providers, local early intervention systems and/or out-of-state; or
    - Exit the early intervention system to another early intervention system within Virginia, early childhood special education services through the local school division, an early intervention system out-of-state and/or other community programs.
  - d. Provide identifying information and a request for evaluation to the special education director or designee of the local school system in order to make a

referral for early childhood special education services under Part B. It is important to be clear that this is a referral for evaluation, since a referral for screening does not begin the timeline for eligibility determination under Part B. The referral information may be provided by phone, fax, secure email or mail. The point at which the special education director (or designee) receives this information is considered the date of referral. Unless otherwise agreed to with the local school division, referrals should be made no later than April 1 in a given year or at least 6 months prior to the child's third birthday, with parent consent. Local Infant & Toddler Connection systems and local school divisions have the option to work out other timelines for referrals and are expected to document any alternate timelines in a local interagency agreement.

- e. Transmit, with parental permission, child-specific information (e.g. current IFSP, recent assessment findings, and other pertinent records) to the appropriate school division in which the child resides as soon as possible after referral.
- f. Ensure that families whose children are referred to the local Infant & Toddler Connection system close to the child's third birthday or after April 1 when the child will reach the age of eligibility for special education at the beginning of the upcoming school year are informed of services available through the public schools and that, with parental permission, child-specific information is shared with the local school division as soon as possible following referral to the local Infant & Toddler Connection system.
  - When the child's age at referral to the Infant & Toddler Connection of Virginia means the child will no longer be age eligible for Part C services by the time the Part C process can be completed (e.g., eligibility determination, assessment for service planning, IFSP development and beginning services), then the child may be referred directly to the local school division for early childhood special education services under Part B.
  - For children who are close to the age where they will transition, but for whom the Part C process can be completed, the single point of entry must inform parents of their options for services through the local division under Part B) and/or the local Infant & Toddler Connection system (under Part C).
  - The family can choose to refer themselves to the local school division for early childhood special education services under Part B at the same time they make the referral to the Infant & Toddler Connection system. They should make both systems aware of the dual referral. If the family has not already referred themselves to the local school division, the service coordinator can assist the family by making this referral, with parent consent. The local Infant & Toddler Connection system and the local school division should work together during the eligibility determination process and assessment for service planning to avoid duplication of assessments.

Requirements Associated with Late Referrals:

- If a child is referred to Part C fewer than 45 days before the child's third birthday and the family opts to proceed with the Part C referral, then the local Infant & Toddler Connection system may, but is not required to, develop a transition plan as part of the IFSP and provide LEA notification for this child.
- If a child is referred less than 90 days before the child's third birthday, then the local Infant & Toddler Connection system may, but is not required to, hold a transition planning conference.
- If a child is referred to Part C at least 45 days before the child's third birthday and the child is found eligible and is receiving services under Part C, then the local Infant & Toddler Connection system must develop a transition plan (generally this would be part of the initial IFSP) and provide notification to the LEA.

These same requirements and timelines apply to a child referred close to the time he/she would be eligible to start school at 2 years old if the family wishes to transition to Part B at the beginning of the school year in which the child turns 2 by September 30.

- g. Assist the family in exploring alternative settings, if desired by the family, for:
  - The child who is not eligible for early childhood special education services under Part B through the local school division and who continues with Part C supports and services until the third birthday;
  - The child whose family chooses not to receive early childhood special education services under Part B through the local school division and who continues with Part C supports and services until the third birthday; or
  - The child who is no longer eligible for Part C supports and services prior to the third birthday.
2. Notification to the LEA (Local Educational Agency, which is the local school division)
  - a. Notify parents of all children who are potentially eligible for early childhood special education services under Part B through the local school division of the local Infant & Toddler Connection system's intent to share the child's name, address, telephone number, and birth date with the appropriate local school division as the child reaches the age of eligibility for special education unless the parent disagrees.
    - Notification to the local school division is a child find activity, and children in Part C are considered "potentially eligible" for Part B unless there is a clear expectation that they will no longer require services by the time they reach age 3. The determination of whether a particular child in Part C is potentially eligible for Part B is made by that toddler's IFSP team as part of the transition process.
    - The information sent to the local school division as part of the notification may also include the service coordinator's name and contact information and the language(s) spoken by the child and family to further assist the local school division in meeting its child find responsibilities.
  - b. Document this notification on the IFSP transition page and specify the date on which the locality intends to send the information to the school division. Since



children in Virginia are age eligible for Part B services at the start of the school year in which the child is 2 by September 30, the date entered in the notification box must be no later than the April 1 prior to the start of the school year in which the child turns 2 by September 30. If the parent opts out of notification at that time, they may use the "I have changed my mind..." line in the Notification box on page 7 of the IFSP to allow notification at a later time, as their child approaches age 3.

- c. Transmit the information to the local school division unless the parent indicates in writing on the IFSP transition page that he/she does not want the information transmitted. Local agencies that require written consent beyond the federal requirement of providing notice (via page 7 of the IFSP in Virginia) can follow their agency requirements to obtain consent at the time of the initial IFSP for release of the child's name, address, phone number and date of birth.

### 3. Transition Planning Conference

- a. Provide written prior notice and obtain parent approval to convene the required conference between the sending Infant & Toddler Connection system providers, the family, and the local school division that occurs at least 90 days, or up to 9 months, prior to the child's eligibility for early childhood special education services under Part B. By Virginia regulation, children are eligible for early childhood special education services at the start of the school year in which the child turns 2 by September 30th. If the family would like the child to transition to early childhood special education services under Part B at the start of the school year in which the child turns 2, then the transition planning conference must be held at least 90 days before the start of the school year. Some local school divisions allow eligible children to begin early childhood special education services throughout the year, as they turn 2. In this case, the transition planning conference must be held at least 90 days before the child turns 2. If the family chooses to delay transition to early childhood special education services under Part B until the child's third birthday (or to delay transition until some point before the child's third birthday), then the transition planning conference must be held at least 90 days before the child's third birthday.
  - Provide a copy and explanation of the *Parental Prior Notice* form (with a check mark by "The required transition planning conference is necessary.") and the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System* to the family. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
  - Explain the purpose of the transition planning conference: To discuss potential options for supports and services through the school system or other community program and establish a plan for a smooth transition from early intervention services to early childhood special education or other community services.
  - Document parent approval for the transition planning conference on page 7 of the IFSP form (see IFSP Instructions at the end of Chapter 7) and in a contact note. Verbal approval by the family is sufficient and no approval form or signature is required.

- If the parent declines the conference, that decision also is documented on page 7 of the IFSP form and in a contact note.
  - If the IFSP team, which includes the family, determines the child is not potentially eligible for Part B, then a transition planning conference is recommended but not required (see the first point under “b” below). The decision by the IFSP team that the child is not potentially eligible must be documented in a contact note.
- b. Ensure scheduling of the transition conference within the required timelines and participation by required parties, including local school division personnel.
  - Since the transition planning conference is intended to provide the family with information about their options for services after leaving the Infant & Toddler Connection of Virginia system, service coordinators are encouraged to offer this conference to families well in advance of transition, closer to the 9 months than the 90 days. This allows the family time to consider their options and plan ahead for any necessary referrals or other steps necessary to ensure services are in place for a smooth transition at age 2 or age 3.
    - For families that wish to consider options in addition to or instead of early childhood special education services through the local school system, service coordinators should make every effort to include representatives from other community programs (e.g., head start, preschool/child care programs) in this transition planning conference. These representatives can explain the services available through their programs including timelines and requirements for enrollment.
  - The local school division representative must be an individual who is knowledgeable about the services available in the local school system. The local school division representative does not need to be the special education director or any other specific position. The key is that the local school division representative is able to provide information and answer questions regarding the continuum of supports and services available through the school system, as well as participate in developing the transition plan with the family. This may be the ECSE (early childhood special education) teacher, a speech therapist or other related service provider who sees children in the early childhood special education program, or child find person for the school division.
  - While a face-to-face meeting among all participants is preferable, participation by teleconference and/or videoconferencing are acceptable methods as well. In that rare instance when the local school division representative cannot participate in any of these ways, the local Infant & Toddler Connection system must provide parents at the conference with information about early childhood special education services through the local school system, including a description of the Part B special education eligibility definitions, timelines and process for consenting to an evaluation and conducting eligibility determinations under Part B, and the availability of special education and related services. The local school division must provide the family with a contact name and phone number where the family can call with questions about school services.

- The transition planning conference must be an individual conference for each family and cannot be a group meeting involving several families or a community event with representatives of multiple transition destinations available to meet with all families.
- c. Ensure that the family is included in any transition planning conference, that the family understands the purpose of the meeting, and that the family is supported in identifying the steps to be taken to support the transition process. Provide the family with the name and contact information for an individual from the local school division that they can contact with any questions following the transition planning conference.
- d. Provide the family with a contact person at the school division to answer any questions they have about school services, if the family declines to participate in a transition planning conference.
- e. Document the transition plan developed during the transition planning conference. The transition plan is an outline of the steps that will be taken in the process of helping the child and family move from the Infant & Toddler Connection system to early childhood special education services through the local school division or to other community services, as appropriate, for children who are not going to the local school division. The “plan” can be documented in contact notes and/or on page 7 of the IFSP. If it is documented in a contact note, then a notation must be made on page 7 of the IFSP referring to the contact note by date. If the family requests more time to think about the transition plan, then the plan developed during the transition conference would list transition steps that were identified during the meeting and/or note that the family requested time to think about the information discussed and that follow-up will occur at a given time to determine with the family how they would like to proceed with transition planning. As discussions continue, the service coordinator must document the additions and/or changes to the transition plan that was started in the transition planning meeting.
- f. Make every effort to participate in the initial Individualized Education Plan (IEP) meeting for children transitioning to early childhood special education services if invited by the local school division at the request of the parent.

#### Discharge and Determination of Child Progress at Exit

Children and their families exit the local Infant & Toddler Connection system for a variety of reasons, which include but are not limited to the following: they move out of the area served by the local Infant & Toddler Connection system, either to another state or to another local Infant & Toddler Connection system within Virginia; the family decides to withdraw from the system; the child and family are lost to contact; the child no longer has a developmental delay, atypical development or a diagnosed condition; the child transitions to early childhood special education services through the local school division or to other community services; or the child reaches his/her third birthday.

#### Service Coordinator Responsibilities:

1. Ensure exit ratings on all three child indicators (positive social relationships, acquiring and using knowledge and skills, and taking appropriate action to meet needs) are done prior to exit for all children who had an entry rating **AND** who have been in the system for 6 months or longer since their initial IFSP. The rating must be done no more than 6 months prior to exit from Part C. Since the ratings reflect the child's status at the time of the assessment, it is beneficial to time the exit assessment/rating as close to exit as

possible in order to capture results for the full time the child was receiving early intervention services. Since the intent of Virginia's System for Determination of Child Progress is to measure children's progress in Virginia's early intervention system, the exit ratings are done only at the time the child leaves Virginia's early intervention system, not when the child leaves one local system to enter a different local system.

a. To complete the exit ratings:

- Using information from parent report, an assessment instrument, observation and other sources, determine the child's status (rating) for each of the indicators. A formal assessment is not required. Instead, the provider(s) determines the child's developmental levels in all areas through ongoing assessment (which can occur over multiple sessions). The provider must document the child's abilities by filling in an assessment instrument (such as the HELP, ELAP, etc.). It is not necessary to use the same instrument that was used for the entry assessment.

-OR-

Obtain entry ratings from the local school division to use as the exit ratings for the Infant & Toddler Connection system. If Part B entry assessment data is being used for the Part C exit assessment data, then that Part B assessment must occur no more than 3 months after the child's discharge from Part C.

- The IFSP team considers information from the sources listed above to determine the child's status in relation to same-age peers for all three indicators. Document the child's functional status in the child's early intervention record. This can be done in a contact note. Also document the sources of information used in the assessment process.
  - The front page of the Child Indicator Summary Form (CISF) is completed, including questions 1b, 2b and 3b. Complete the back page if documentation in the child's record is not sufficient to support the rating decisions and/or if the source of the information used to make the determination is not documented in the child's record. The yes/no response to the *b* questions (Has the child made progress?) must always be based on the child's progress since the initial assessment, even if there has been one or more interim assessments.
- b. There will be situations where it is not possible to complete the ratings because children/families leave the system without notice. This must be documented in a contact note.
- c. The local Infant & Toddler Connection system's exit ratings may serve as the local school division's entry ratings under Part B, and the local school division's entry ratings may be used for the local Infant & Toddler Connection system's exit ratings under Part C (as long as the Part B assessment occurs no more than 3 months after the child's discharge from Part C). Local systems are strongly encouraged to collaborate with their local school division representatives to establish mechanisms to accomplish this sharing of data and non-duplication of assessment.
- d. Enter the child's exit ratings into ITOTS, recording the mitigating circumstances if the local system was unable to complete the exit ratings.

The documents available at <http://www.infantva.org/ovw-DeterminationChildProgress.htm> can provide further guidance and assistance in determining exit ratings.

2. Provide a copy and explanation of the *Parental Prior Notice* form (with “Your child is not eligible for Infant & Toddler Connection of Virginia” marked) and the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System* to the family. Parental prior notice must be provided to the family at least 5 days before early intervention services will be terminated.
  - a. If the child is no longer eligible (but is within the age range for Part C services), the reason listed on the *Parental Prior Notice* form will explain that ongoing assessment results indicate that the child no longer meets the eligibility criteria for Part C. In explaining the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*, review and explain the complaint procedures. Even if the family has already received a copy of the Notice of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined.
  - b. If the child is “aging out” of Part C, the reason listed on the *Parental Prior Notice* form will be that “Your child will be turning three years old on \_\_\_\_\_. Effective on that date, your child is no longer eligible for early intervention services through the Infant & Toddler Connection of Virginia.”
  - c. If the child is transitioning to early childhood special education services under Part B, the reason listed on the *Parental Prior Notice* form will be that “Your child will soon be receiving early childhood special education services through your local school division. On the date Part B services begin, your child is no longer eligible for early intervention services through the Infant & Toddler Connection of Virginia.”

It is not necessary to provide parental prior notice if the family is moving out of the area served by the local Infant & Toddler Connection system or if the family has stated that they wish to withdraw from services (since, in these situations, the system is not proposing to end services).

- a. If the child is moving out of the area served by the local Infant & Toddler Connection system, then any referrals made must be documented in the service coordinator’s contact notes.
  - b. If the parent decides to withdraw from services, then the service coordinator documents the parent’s decision in a contact note.
3. For Medicaid recipients only: If the family is receiving prior notice that their child is no longer eligible (but is within the age range for Part C services): Complete and provide the family with the *Early Intervention Services – Notice of Action* letter and explain to the family their right to appeal under Medicaid if they disagree with the multidisciplinary team’s determination that their child is no longer eligible for early intervention services. Point out where additional information about the appeal process is located in the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*.
4. Ensure that copies and explanations of procedural safeguard forms are provided in the family’s native language or other mode of communication unless clearly not feasible to do so.
5. **Ensure that no IFSP services are delivered on or after the child’s third birthday.**
6. Enter discharge information into ITOTS as children exit the local Infant & Toddler Connection system, within 10 business days of discharge.

### ITOTS Data Entry – IFSP Implementation and Review

The local system manager ensures the following information is entered into ITOTS:

1. Discharge Date
2. Status/Transition Destination
3. Exit assessment and child progress data

[Complete ITOTS instructions are available at

<http://www.infantva.org/documents/forms/INST1117eR.pdf>]

### Local Monitoring and Supervision Associated with IFSP Implementation and Review

The local system manager provides the supervision and monitoring necessary to ensure the following:

1. Procedural safeguards forms are used and explained appropriately
2. Services begin in a timely manner
3. Mitigating circumstances are documented when services begin more than 30 days after the family signs the IFSP
4. Efforts to secure foreign language and sign language interpreters to communicate with the child during service delivery and to assist the family's active participation in periodic reviews are documented
5. IFSP reviews and annual IFSP meetings are held in accordance with required time frames
6. All IFSPs include transition planning
7. Notification to the LEA occurs for all potentially eligible children (as long as the family does not disagree) and is documented
8. The transition planning conference occurs within required time frames and with required participants.
9. Mitigating circumstances are documented when the transition conference does not occur within required time lines.
10. Child indicator exit ratings are appropriate based on the documentation of child functioning.
11. ITOTS data entry is timely and accurate
12. The monthly Medicaid Enrollment Report, Change Report and Claims Report are reviewed and the Part C Office is notified of any discrepancies between the Medicaid reports and the local information to ensure Medicaid EI enrollment and reimbursement are correct.
12. Medicaid/FAMIS and other insurance eligibility are checked at least monthly for all children receiving services through the Local Lead Agency and the Part C Office is contacted immediately for children who have Medicaid/FAMIS coverage but are not showing the EI benefit. Options for verifying a child's Medicaid/FAMIS coverage are discussed in the "Family Cost Share Practices" section of Chapter 11 (see the text box titled "Medicaid/FAMIS and Medicaid EI Benefit Eligibility Verification").

## Chapter 9: The Early Intervention Record

### The Early Intervention Record

#### Local Lead Agency Responsibilities:

1. Maintain each child's early intervention record at the local lead agency or the local agency that houses the system's service coordinators. It is acceptable to have early intervention records located at satellite offices of the local lead agency or service coordinators' agency (e.g., if the local lead agency is the CSB and the CSB has offices in multiple cities or counties in the catchment area, then records may be kept at any of those CSB offices) as long as there is easy access to the records by local lead agency administrators for billing and supervision purposes.
2. Make children's early intervention records available to the State Lead Agency, the Department of Behavioral Health and Developmental Services, upon request and at the location designated by the State Lead Agency.
3. Ensure that each child's one early intervention record includes the following:
  - a. Accurate demographic and referral information
  - b. Signed releases and consents
  - c. Other completed procedural safeguards forms
  - d. Screening and assessment reports
  - e. Medical reports
  - f. All other documentation collected during eligibility determination and IFSP development including reports from previous outside screenings, assessments, etc.
  - g. Completed Eligibility Determination form
  - h. All IFSPs developed – current and past, including documentation of periodic reviews
  - i. Child Indicator Summary Form (unless the required information is fully documented on the IFSP for the initial indicator status and in a contact note for the exit status and the rating number is recorded in ITOTS)
  - j. Contact logs or contact notes submitted by providers, including service coordinators
  - k. Copies of all correspondence to and from the local Infant & Toddler Connection system or its providers with or on behalf of the family
  - l. Court orders related to service provision, custody issues, and/or parental rights
  - m. Signed *Family Cost Share Agreement* form, unless it is kept in a separate financial file – If the agreement form is filed in the early intervention record, it is recommended, but not required, that there be a separate section for financial information within the record, particularly for any information stored that documents the family's income or expenses.
  - n. Record Access log

#### Early Intervention Provider (Including Service Coordinator) Responsibilities:

1. Maintain a clinical/working file that must include, at a minimum, a copy of the IFSP (including reviews), the individual provider clinical treatment plan if any, contact notes, and any completed screening and/or assessment protocols if not housed in the early intervention record. Providers working in the agency where the early intervention record is housed have to the option to maintain the items listed above in the early intervention record instead of in a separate clinical/working file.
2. Make contact notes available to the State Lead Agency or local lead agency upon request.

### Contact Notes

The term “contact note” will be used in discussing below how Part C early intervention service provision, including service coordination, is to be documented. The term “contact note” is intended to be interchangeable with other commonly used terms such as “progress note,” “case note,” or “service coordination note.” Local Infant & Toddler Connection systems and early intervention providers are not required to call their documentation contact notes.

Effective and complete contact notes are critical in order to address the following purposes of such documentation. Part C contact notes are:

1. A chronological record of the child’s and family’s participation in the Infant & Toddler Connection system (including the supports and services provided to the child and family), the course of intervention, and the child’s developmental progress. Therefore, thorough contact notes:
  - a. Provide an objective basis to determine the appropriateness, effectiveness and necessity of intervention, and
  - b. Assist the IFSP team in assessment and service planning at IFSP reviews and annual IFSPs.
2. A means for communication among service providers and with the family.
  - a. Not only do thorough contact notes facilitate communication among current service providers, but they also provide critical information to substitute providers who fill in when the usual provider is ill or on vacation and to new providers who begin services after an IFSP review or annual IFSP or when the former provider is no longer providing services to that child and family.
  - b. Under Part C, parents have the right to review their child’s record.
3. Billing documents.
  - a. Contact notes are used for billing purposes and must provide the information required by Medicaid and other third-party payors.
4. Monitoring documents.
  - a. Contact notes are reviewed by local system managers, program managers, State Part C personnel, and Medicaid personnel to monitor compliance with federal and State requirements and to facilitate quality assurance and improvement. Contact notes that are complete and accurate will assist local systems in documenting compliance and improvements.
5. Legal documents.
  - a. Contact notes are legal documents and may be used in the investigation of an administrative complaint or in a due process hearing under Part C, or in a court case such as a custody dispute. Thorough contact notes are essential in documenting compliance with Part C requirements, provision of supports and services in accordance with the IFSP, reasons for missed appointments, and other contacts and activities completed on behalf of the family.

### General Rules for Contact Notes:

1. Document all contacts made and all activities completed with or on behalf of the child and family. This includes, but is not limited to, phone calls (including “no answer” or a “voice message left”), face – to – face contacts, consultations between providers related to the child and family but not with the child and family, and written correspondence. If someone is looking at a child’s record and a contact or activity is not written down, then the reviewer must assume that the contact or activity did not occur.
  - a. If two or more providers participate in the same treatment session, then they may each write a separate note documenting their time and activities or there may be



one note to document the team treatment as long as that note clearly documents each provider's time and how each participated in the session. If a joint note is written, it must be signed by each provider. The option to write a joint contact note does not apply if separate sessions (e.g. at two different times) by two different providers occur on the same day.

- b. If one provider is performing two roles during a single visit (e.g., one provider is delivering service coordination and developmental services), then that provider may write one note specifying the amount of time spent and activities completed in each role.
- c. If one provider participated in two different activities on the same day (e.g., assessment for service planning and the IFSP meeting), then that provider may write one note specifying the amount of time spent and his/her role in each activity (assessment and IFSP meeting). It is acceptable to refer in the note to the IFSP for the specifics about assessment information and IFSP decisions made rather than repeating that information in the note.
- d. If there is communication related to a child who has been discharged from the local system, then such communication would require a contact note, which must be filed in the child's early intervention record.
- e. If someone other than the service coordinator or other service provider (e.g., a program supervisor or the central point of entry) gets a call from the family, then that contact must be documented in a contact note, which is then filed in the child's early intervention record.

Do I Need to Write a Contact Note?

- To document my participation in an assessment or an IFSP meeting? **Yes**
- To document provision of procedural safeguards? **Yes**
- To document what services are planned? **No**, page 6 of the IFSP is sufficient documentation of planned services.

Not sure if you need to write a note? It's better to go ahead and write one!

2. Use contact notes to provide essential information that is not contained in meeting record forms such as the IFSP.
  - a. The service coordinator must complete a contact note following the IFSP meeting to document the following:
    - The length of the IFSP or IFSP review meeting in minutes unless this is documented on the IFSP/IFSP review form. Since providers are billing for these services, the time spent must be clearly documented.
    - Any supports and services recommended by the team but not accepted by the family.
    - Instances where the family opted for a frequency, intensity, or method of service that was different than what was proposed by other team members.
    - Any other areas of disagreement among team members, including the resolution reached or, if the issue was not resolved, the plan for addressing the area of disagreement; and the rationale for planning a later start date for services, when applicable.

3. Document the reasons for cancellation (whether cancelled by the provider or the family) any time a contact was scheduled and did not occur. The more specificity provided, the more helpful the contact note is for individuals monitoring and/or using contact notes for billing.
4. Document that native language requirements have been met if the native language is other than English.
5. Write legibly.
6. Use the provider agency's rules regarding ink color for contact notes. Generally, black ink is preferred since it works best for faxing and copying.
7. Provide complete and accurate information about the contact or activity, ensuring that a third party could read the contact note and understand what occurred.
8. Record events and observations in a factual, non-judgmental way and avoid subjective comments.
9. Use positive statements.
10. Use language understood by all team members, including the family. Avoid jargon and abbreviations or explain them in the note.
11. Complete contact notes in a timely manner, no more than 3 working days from the time of the contact.
  - a. Day 1 of the 3-working-day timeline is the day the service was provided/contact was made.
  - b. The 3-working-day timeline applies only to having the note written and does not require that the contact note be placed into the child's early intervention record within that same period of time.
  - c. If a handwritten note (that is to be transcribed into the electronic health record) is completed within three working days, that meets the requirement even if the note is not entered electronically until after the 3-working-day deadline.

Ideally, the contact note should be done immediately following the contact to ensure optimal recall of what occurred and so that the note is available for other team members who may need the information for their service provision to the family.
12. Correct errors on handwritten contact notes by drawing a single line through the incorrect information, providing the date of the correction and the initials of the reviser, then adding the correct information. Correct errors in electronic documentation by following agency requirements or using strike-through and providing the date and initials of the reviser. White-out, or any other means of correction other than that described here, may never be used to change the contact note.

#### Specific Content Requirements for Contact Notes:

##### **For all contact notes -**

1. Child's first and last names – If there is more than one contact note on a page, it is acceptable to have the child's first and last name on each page of contact notes rather than on each note itself (the name must appear on both sides of the paper if both sides are used for contact notes).
2. Type of service provided (physical therapy, developmental services, service coordination, etc.)
3. Type of contact (phone, face-to-face, e-mail, etc.)
4. Date of the note and date of service or contact, if the note is not written on the same date. If the contact described in the note occurred prior to the date of the note, then the date of the contact should be contained in the body of the note (e.g., "4/5/06 – On 4/4/06 service coordinator participated in Joe's IFSP meeting."). If a contact note is handwritten on one day and later typed or entered into an electronic record the date of the note would be the date it was handwritten.

5. Provider signature (with at least first initial and last name), discipline and credentials of provider and the date the note is signed by the provider. The signature of the provider must be handwritten or electronic; no stamps allowed.

**For contact notes documenting a service session with the child and family, also include the following:**

1. A **narrative** description of what occurred during the session including what was done, how the family/caregiver participated, how the child responded during the session (including what the child was able to do in relation to outcomes, goals, etc.), and suggestions for follow-up. A contact note formatted as a check-off list does not provide the level of information required to know what occurred during the session.
2. Who was present
3. Length of session (in minutes)
4. Location/setting (e.g., home, day care, etc.) in which the service was provided
5. Information from the family/caregiver about what has happened since the last visit. [The contact note should make clear that the information is from the family by using phrases like “as reported by (family member),” or “(Caregiver) reports....”]
6. Plan for next contact.

A contact note checklist is provided at the end of this chapter.

### Access to Records

The local lead agency may assume that the parent has the authority to inspect and review records relating to his or her child unless the agency has been advised that the parent does not have the authority under applicable Virginia law governing such matters as guardianship, separation, and divorce.

### Local Lead Agency/Provider Responsibilities:

1. Identify one individual to assume responsibility for ensuring the confidentiality of any personally identifiable information;
2. Provide training or information on Part C confidentiality requirements (in accordance with FERPA) to all individuals collecting or using personally identifiable information;
3. Provide parents, upon request, a list of the types and locations of records collected, maintained, or used for Part C by the local lead agency/provider.
4. Establish a procedure for parents or a representative of the parent to inspect and review the child's record(s) collected, maintained or used for Part C;
5. Keep a record using the *Access to Record* form of person(s), except parents and authorized employees, obtaining access to records collected, maintained or used by the local lead agency/provider, including the name of the person(s), date of access and purpose of access;
6. Respond to a parent request to amend information considered to be inaccurate or misleading or which violates the privacy or other rights of the child or family by:
  - a. Amending the information in accordance with the request within a reasonable period of time of receipt of the request; or
  - b. Informing the parent of the local lead agency's refusal to make the requested amendments and advising the parent of their right to a hearing, as described in the *Notice of Child and Family Rights and Safeguards in the Infant and Toddler Connection of Virginia Part C Early Intervention System*.
7. Not charge a fee for copies of records if the fee would effectively prevent the parents from exercising their right to inspect and review those records.

8. Inform parents when personally identifiable information collected, maintained, or used is no longer needed to provide supports and services to the child and destroy the information at the request of the parents. Permanent records of the child's name, address, phone number, and time period in which they received supports and services may be maintained.
9. Ensure the early intervention record is maintained for a minimum of 3 years following the child's discharge from the Infant & Toddler Connection system. Local lead agencies have the option to require records be maintained for a longer period. The 3-year time period ensures access to the records in case dispute resolution or due process proceedings requesting reimbursement of any kind occur after the child's discharge.

Service Coordinator Responsibilities:

1. During the intake visit, point out where information related to storing, accessing, and correcting records is included in the *Notice of Child and Family Rights and Safeguards in the Infant and Toddler Connection of Virginia Part C Early Intervention System*. Remind parents of this information when reviewing the Notice of Child and Family Rights and Safeguards at other required points in the early intervention process.

## Contact Note Checklist

### Contents:

#### **For all contact notes:**

- ☐ Child's first and last name - on the note or the page
- ☐ Type of service provided (e.g., service coordination, physical therapy, etc.)
- ☐ Type of contact (e.g., phone, face-to-face, mail, etc.)
- ☐ Date of contact note
- ☐ Date of service/contact (if different than date of note)
- ☐ Location/setting in which the service was provided
- ☐ Signature of provider (at least first initial and last name; handwritten or electronic, no stamp)
- ☐ Title of provider
- ☐ Date of provider signature

#### **For contact note on a service session with child and family, must also include:**

- ☐ Who was present (The note must specify that the child was present if billing Medicaid)
- ☐ Length of the session in minutes
- ☐ A narrative that includes the following:
  - ☐ Information from family/caregiver about what has happened since last session
  - ☐ What the provider did during the session including interventions/methods
  - ☐ What the family/caregiver did during the session
  - ☐ What the child did during the session, including specifics about what the child did in relation to the IFSP outcomes and short-term goals
  - ☐ Suggestions for follow-up during daily routines, including
    - ☐ Support and instruction provided for the family
    - ☐ Any adjustments needed to intervention strategies and activities
  - ☐ Sufficient information to allow the reader to know what occurred during the session and what support and suggestions were provided for follow-up during daily routines
- ☐ Plan for next contact

### Other:

- ☐ Handwriting is legible
- ☐ Language used can be understood by all team members, including the family.
- ☐ Events and observations are recorded in a factual, non-judgmental way
- ☐ Information is presented in a positive manner
- ☐ Note is completed within 3 working days of contact
- ☐ Errors on handwritten notes are corrected by a single line through incorrect information, citing date of the correction and initials of reviser then adding correct information. Errors in electronic documentation are corrected by following agency requirements or using strike-through and providing the date and initials of the reviser. White-out, or any other means of correction other than that described here, may never be used to change the contact note.

## Chapter 10: Dispute Resolution

Every effort should be made to resolve family-provider disagreements using informal decision making. If informal decision making is unsuccessful, parents may choose, by filing a written request to the State Lead Agency, the Department of Behavioral Health and Developmental Services (DBHDS), one of the following options:

1. Administrative complaint;
2. Mediation alone;
3. Mediation and a due process hearing simultaneously; or
4. A due process hearing alone.

In addition to the dispute resolution options available through the Infant & Toddler Connection of Virginia, Medicaid recipients have the right to file an appeal with the Department of Medical Assistance Services when they disagree with certain actions. Actions that may be appealed include disagreement about:

- The child's eligibility for Part C services;
- The development of an Individualized Family Service Plan (IFSP) within 45-calendar days from the date of referral to the Infant & Toddler Connection system;
- The provision of early intervention services, including those listed on an Individualized Family Service Plan (IFSP); and
- The frequency and intensity of the IFSP services.

Appeals must be requested in writing and postmarked within 30 days of receipt of the *Parental Prior Notice* form documenting an "adverse action." The family or their authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at [www.dmas.virginia.gov](http://www.dmas.virginia.gov) and through a link on the Infant & Toddler Connection of Virginia's website at [www.infantva.org](http://www.infantva.org). The *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System* provides additional information about the process of filing a Medicaid appeal.

### Service Coordinator Responsibilities:

1. Ensure that when disagreement occurs on matters relating to identification, eligibility determination, or placement of the child or the provision of appropriate early intervention supports and services under Part C for the child and family, the parent of the child is informed, in writing and verbally, of the options for resolution. The *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System* and *Strengthening Partnerships: A Guide to Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System* provide written information about the options for dispute resolution. The *Strengthening Partnerships* document is an especially helpful tool for service coordinators to use in reviewing this information with families.
  - a. For Medicaid recipients only: Complete and provide the family with the *Early Intervention Services – Notice of Action* letter and explain to the family their right to appeal under Medicaid any time there is an adverse action proposed by the Infant & Toddler Connection system (e.g., the child is found ineligible, the local system is refusing to initiate a service the family is requesting or is refusing to provide a service at the frequency/intensity desired by the family, the IFSP team is proposing to end a service). Point out where additional information about the appeal process is located in the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*.

2. Provide the family with a contact at DBHDS who can:
  - a. Offer them technical assistance in framing their complaint, including language interpreters as requested and/or reducing oral complaints to writing; and
  - b. Inform them of individuals and organizations who provide free or low cost legal or lay assistance to persons who wish to lodge a complaint (such as parent training and information centers, protection and advocacy programs, and legal aid organizations).
3. Ensure that during dispute resolution, unless the family and local lead agency agree otherwise, the child and family continue to receive the supports and services on the child's current IFSP.
4. Ensure that if the family-provider disagreement involves initial eligibility to receive supports and services under Part C, the child and family will not receive supports and services under Part C until the eligibility question is resolved.
5. Ensure that if a family chooses to appeal a decision using the Medicaid Right to Appeal procedures, the family also is informed of their options for dispute resolution under Part C.
6. Ensure that families understand their right to bring a civil action in Federal or State court if they are not satisfied by the hearing officer's decision in a due process hearing.

#### Procedures for Mediation:

1. Either party (the family or local lead agency) may request or decline the mediation conference. If the local lead agency declines the mediation, the parents must be informed as soon as possible (within four days) of this decision and the right to pursue a hearing.
2. DBHDS appoints a trained mediator within five (5) days of receiving the request for mediation.
3. The local lead agency appoints a representative to serve on their behalf during mediation.
4. The mediation, including a written mediation agreement reflecting agreements reached by the parties to the dispute, is completed within 15 calendar days of the receipt by the DBHDS of notice that both parties have agreed to mediation. If resolution is not reached within 15 days, DBHDS informs the parents in writing that they may request a due process hearing. Extensions of the 15-day timeline may be granted for good cause. Examples of good cause include injury, illness, or natural disaster. If there is a simultaneous request for mediation and a due process hearing, the extension must not result in a violation of the 30-day timeline for completion of the due process hearing.
5. At any time during the mediation process, a request for a due process hearing may be initiated.
6. DBHDS bears the full cost of the mediation process.
7. A flow chart of the process for requesting and using mediation to resolve disagreements is provided at the end of this chapter.

#### Procedures for a Due Process Hearing:

1. DBHDS arranges for the appointment of an impartial hearing officer within five days following receipt of the request for a hearing.
2. The due process hearing is carried out at a time and place that is reasonably convenient for the parents.
3. Any family involved in a due process hearing has the right to:
  - a. Be accompanied and advised by counsel and by individuals with special knowledge or training with respect to early intervention supports and services for children eligible under Part C;

- b. Present evidence and confront, cross-examine and compel the attendance of witnesses;
  - c. Prohibit the introduction of any evidence at the proceeding that has not been disclosed to the parent at least five days before the proceeding;
  - d. Obtain a written or electronic verbatim transcription of the proceeding; and
  - e. Obtain written findings of fact and decisions.
- 4. Costs for resolution of parent/provider disagreements by due process hearing are equally shared by the local lead agency and DBHDS. The costs shared include expenses of the hearing officer (i.e., time, travel, secretarial, postal and telephone expenses), expenses incurred by order of the hearing officer (i.e., independent educational evaluations, deposition or transcript), and expenses for making a record of a hearing (i.e., hearing tapes). DBHDS is not responsible for expenses incurred for witnesses (except where hearing officers subpoena witnesses on their own initiative) or for attorney's fees.
- 5. The hearing officer issues a written decision to all parties within 30 days of receipt by DBHDS of the request for a due process hearing.
- 6. A flow chart of the process for requesting and using a due process hearing to resolve disagreements is provided at the end of this chapter.

#### Procedures for an Administrative Complaint\*:

DBHDS will complete the following steps within 60 days of receiving a written complaint.

- 1. Send notification in writing to each complainant and the local lead agency against which the violation has been alleged, acknowledging receipt of a complaint with copies to other appropriate personnel and the family. The notification sent by DBHDS includes:
  - a. A copy of the complaint;
  - b. A summary of issues to be addressed in resolving the complaint;
  - c. An offer of technical assistance in resolving the complaint;
  - d. A request for written response to the complaint within ten days of the date of the letter of notification. When possible, resolution is reached at the local level during this time.
- If a reply from the local lead agency is not filed with DBHDS within ten days, DBHDS sends a second notice to the local lead agency and telephones the local lead agency.
- 2. Review the complaint and the reply filed by the local lead agency.
  - a. If no further investigation or action is necessary, DBHDS notifies both parties, in writing, stating the resolution.
  - b. If the reply does not resolve the complaint, DBHDS reviews all documentation presented and conducts an independent onsite investigation, if necessary.
- 3. Resolve the complaint based upon the facts and applicable law and notify the parties, in writing, of the decision, including findings of fact and conclusions and the reasons for the final decision reached by DBHDS.
- 4. Address, if it finds a failure to provide appropriate supports and services, the following:
  - a. How to remediate the denial of those supports and service, including, as appropriate, the awarding of monetary reimbursement or other corrective action appropriate to the needs of the child and the child's family;
  - b. Appropriate future provision of supports and services for all infants and toddlers with disabilities and their families.
- 5. A flow chart for filing and resolving administrative complaints is provided at the end of this chapter.

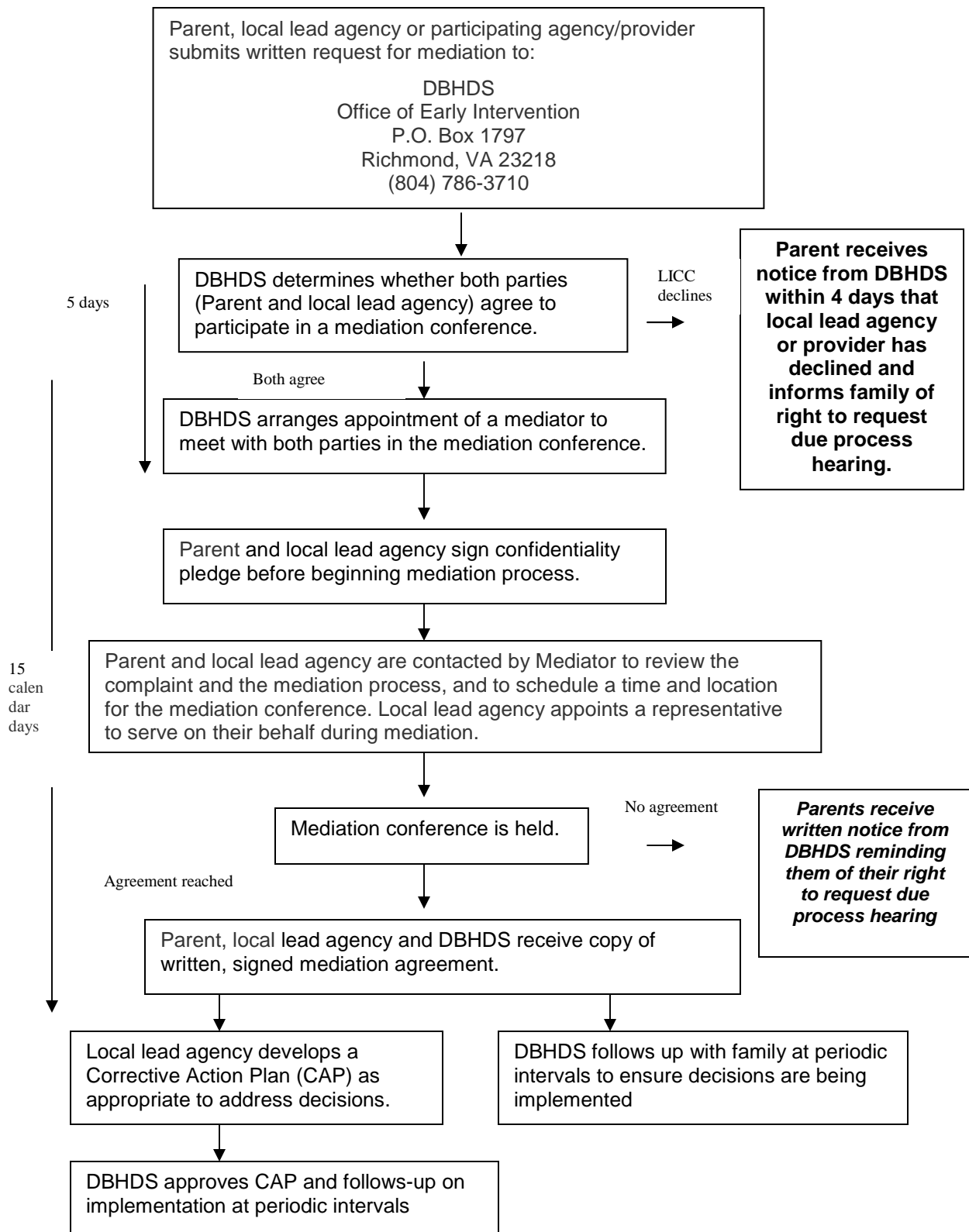
An extension of the 60 calendar day time limit may occur if exceptional circumstances exist with respect to a particular complaint. Both parties to the complaint are notified in writing by



DBHDS whenever exceptional circumstances (e.g., illness, death) exist and the extended time limit is specified.

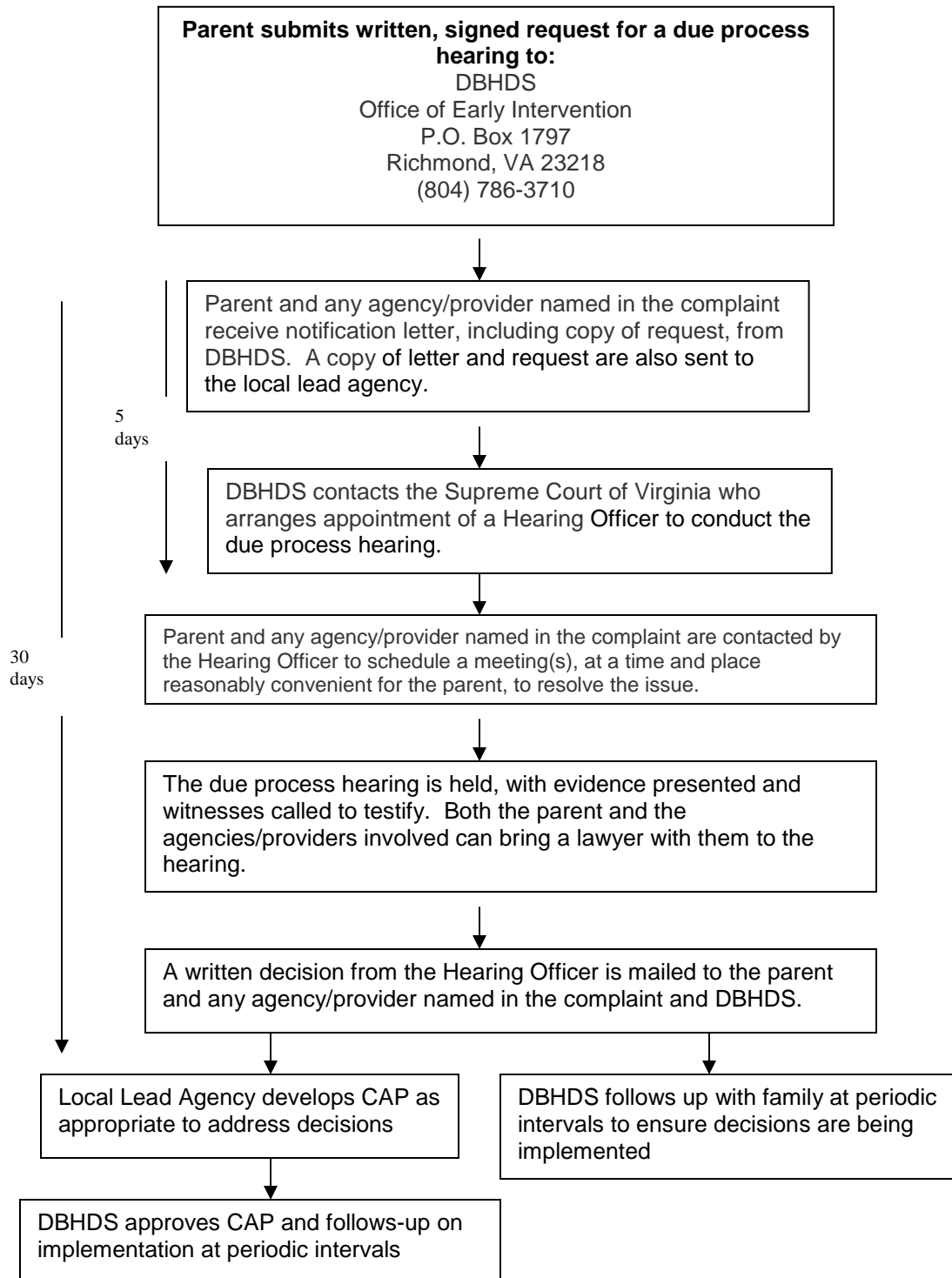
\* If a written complaint is received that is also the subject of a due process hearing, or contains multiple issues, of which one or more are part of that hearing, DBHDS must set aside any part of the complaint that is being addressed in the due process hearing until the conclusion of the hearing. However, any issue in the complaint that is not a part of the due process action will be resolved within the 60-calendar-day timeline using the complaint procedures described above. If an issue is raised in a complaint that has previously been decided in a due process hearing involving the same parties, the hearing decision is binding; and DBHDS informs the complainant to that effect.

## Process for Requesting and Using Mediation to Resolve Disagreements<sup>1</sup>



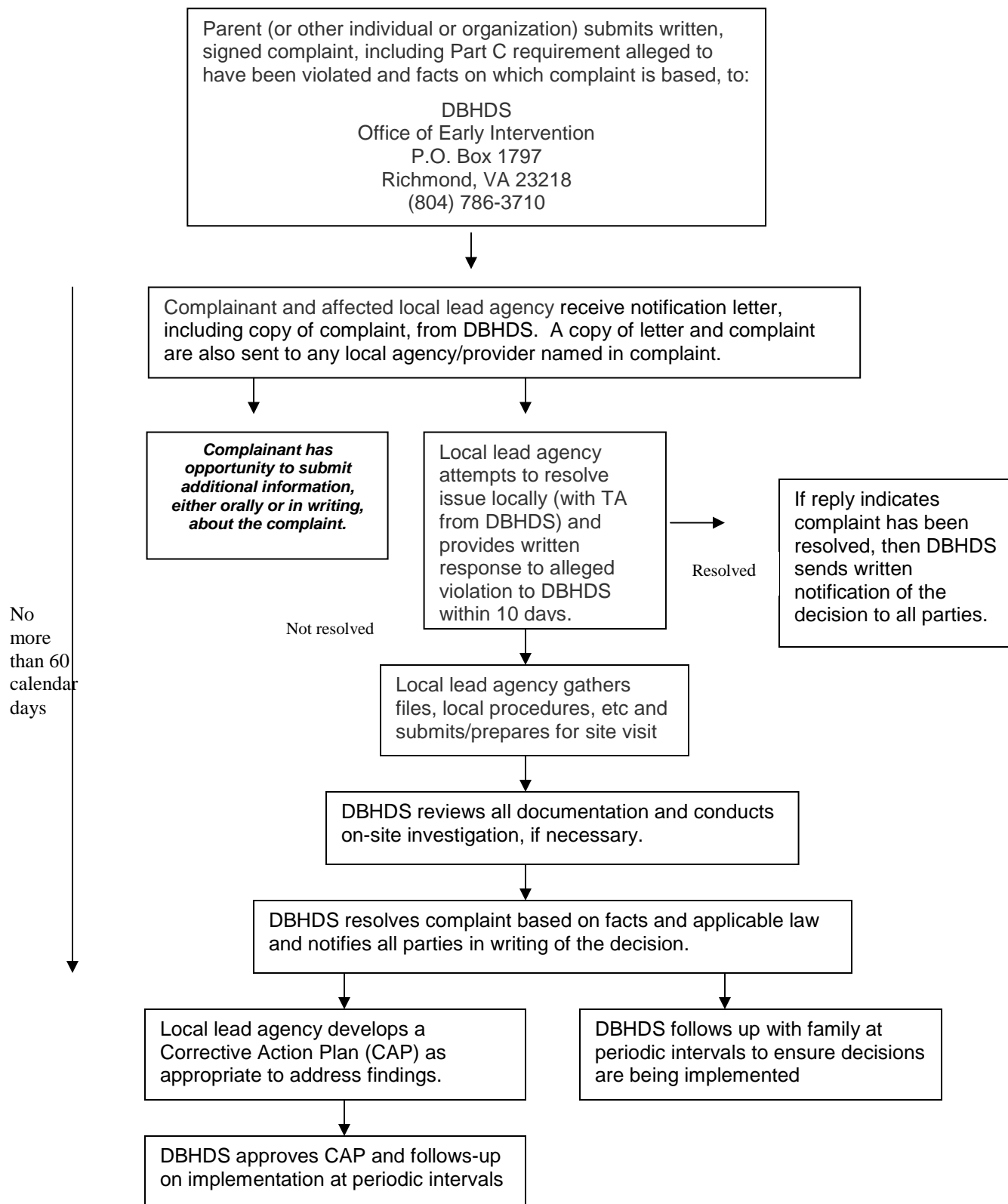
<sup>1</sup> At any time during the mediation process, the parent may request a due process hearing being initiated. Mediation may not be used to deny or delay a parent's rights to a due process hearing.

## Process for Requesting and Using a Due Process Hearing to Resolve Individual Child Complaints<sup>2</sup>



<sup>2</sup> If the parent requests mediation and a due process hearing simultaneously, then the steps in the flow charts for both mediation and due process would take place at the same time and must **all** be completed within 30 calendar days of the receipt of the request (with mediation completed within the first 15 days).

## Process for Filing and Resolving Administrative Complaints



## Chapter 11: Finance and Billing

Finance and billing practices in the Infant & Toddler Connection of Virginia system support compliance with federal Part C requirements to ensure non-supplanting and use of Part C funds as payor of last resort as well as promoting equity and parity across local systems and enhancing access to early intervention supports and services.

### Definitions

1. **Family fee** (or “fee”) – Amount required as payment from families for IFSP services based on the accrued charges and co-payments incurred as a result of the services a family receives each month. The family fee may not exceed the monthly cap.
2. **Monthly cap** (or “cap”) – The maximum amount, as determined by the Family Cost Share fee scale or fee appeal process, that a family will be required to pay per month for IFSP services regardless of the number, type, frequency or intensity of services a child and family receive.

### General

Local Lead Agency Responsibilities:

1. Ensure the following functions are carried out at no cost to families:
  - a. Child find requirements;
  - b. Eligibility determination;
  - c. Assessment (this does not include the ongoing assessment that is integrated into and occurs as a routine part of service delivery);
  - d. Service coordination;
  - e. Development, review and evaluation of IFSPs; and
  - f. Implementation of procedural safeguards.
2. Ensure that the charges for Part C supports and services are consistent regardless of the anticipated payment source.
3. Make every effort during planning and implementation of the interagency system of early intervention supports and services to consider and access all available sources of funds prior to use of state and/or federal Part C funds. Every effort must be made to access private insurance (including private HMOs) and public insurance through the Department of Medical Assistance Services and TRICARE for all Part C supports and services covered by these payors. Other potential resources include, but are not limited to the following:
  - a. Private foundations, civic organizations (i.e., Kiwanis, Lions Club, etc.), and faith organizations that have potential supports/resources for children and families in early intervention;
  - b. Publicly and privately funded initiatives (i.e., Healthy Families, Comprehensive Health Investment Project of Virginia, Early Head Start, etc.) that may have overlapping services and supports for families;
  - c. Public and private agencies/organizations including health/medical, social services, education and mental health agencies; and
  - d. Parent organizations.

Funding for the various steps in the early intervention process (such as intake, determination of eligibility, assessment for service planning, provision of supports and services) varies according to the step in the process and to what is “covered” by the particular funding source. The two *Reimbursement Sources* tables at the end of this chapter show the potential funding sources for each step in the early intervention process.

4. Ensure that, in accordance with the Education Department General Administrative Regulations (EDGAR, §74.24), all income generated by the local Infant & Toddler

Connection system is retained by the local Infant & Toddler Connection system. For the purposes of Part C, income includes public and private insurance reimbursement and income from family fees and fundraising.

5. Develop interagency agreements, contracts or memoranda of agreement with as many providers as possible to meet the needs of children with disabilities and their families. These agreements or contracts must specify the responsibilities of each party including the requirement to comply with Part C of the Individuals with Disabilities Education Act, as well as the supports and services that will be provided and how these supports and services will be financed. Local lead agencies must allow families to have access to any certified practitioner in the family's payor network who is working in the local system area, contracting or otherwise arranging for services with the selected provider if needed to allow for exchange of Part C funds.
6. Implement the family cost share practices specified below to ensure documentation that payor of last resort requirements are met and that no child and family are denied supports and services due to an inability to pay. The family cost share practices also specify the process for documenting the family's choices related to use of public or private insurance and payment of family fees.
7. Implement procedures for the use of Part C funds to cover the cost of supports and services pending reimbursement from the agency or entity that has ultimate responsibility for the payment or pending designation of the responsible agency or entity in order to prevent a delay in the timely provision of supports and services.
  - a. During a dispute between/among local counterparts of participating agencies regarding financial or other responsibilities, the local lead agency notifies the State Lead Agency of the dispute and uses Part C funds until the dispute is resolved to ensure that no supports and services that a child is entitled to receive are delayed or denied. Upon resolution of the dispute, the agency determined responsible reimburses Part C as follows:
    - If reimbursements are not made by a State participating agency (or its local counterpart) within 45 days of resolution of the dispute, the State Lead Agency contacts the staff involved at the State participating agency of the given program.
    - If not resolved by the respective State agency within 14 days, the matter is referred to the Secretary of Health and Human Resources and/or the Secretary of Education.
  - b. Under extraordinary circumstances, Part C funds may be utilized to ensure the provision of services until a monthly cap is determined through the family cost share practices described later in this chapter.

### Early Intervention Rates

Standard rates are in place for reimbursement of early intervention services regardless of reimbursement source (though not all reimbursement sources will reimburse for all services listed below – see tables at the end of this chapter). These rates reflect the full cost of providing a unit of early intervention services, including not only salary and benefit costs but also travel and administrative and support costs. In the case of assistant-level practitioners, the rate also accounts for supervision costs. The table below reflects the standard rate for each type of service:

Service	Location	Provider*	Rate (per 15 minute unit)
Eligibility Determination - Travel required to be with family	Any location	RC 1 + audiologists	\$37.50/unit
		RC 2 + dietitians	\$27.50/unit
Eligibility Determination - No travel to be with family	Any location	RC 1 + audiologists	\$22.50/unit
		RC 2 + dietitians	\$16.49/unit
Initial Assessment for Service Planning	Natural environment or center	Reimbursement category 1 providers	\$37.50/unit
		Reimbursement category 2 providers + dietitians***	\$27.50/unit
		Audiologists***	\$150/assessment
		Physicians	Negotiated individually at local level
Initial or Annual IFSP Meeting	Natural environment or center	RC 1 + audiologists	\$37.50/unit
Team Treatment activities (more than one professional providing services during same session for an individual child/family)	Natural environment**	RC 2 + dietitians	\$27.50/unit
		RC 1 + audiologists	\$37.50/unit
		RC 2 + dietitians	\$27.50/unit
IFSP Review Meeting (child and family present)	Natural environment**	RC 1 + audiologists	\$37.50/unit
		RC 2 + dietitians	\$27.50/unit
Assessments that are done <u>after</u> the initial Assessment for Service Planning	Natural environment**	RC 1	\$37.50/unit
		RC 2 + dietitians	\$27.50/unit
		Audiologists	\$150/assessment
		Physicians	Negotiated individually at local level
Group (congregate) early intervention services	Natural environment**	RC 1 + audiologists	\$25.13/unit
		RC 2 + dietitians	\$18.43/unit
Individual early intervention services	Natural environment**	RC 1 + audiologists	\$37.50/unit
		RC 2 + dietitians	\$27.50/unit
Center-based group (congregate) services	Center	RC 1 + audiologists	\$7.43/unit
		RC 2 + dietitians	\$5.44/unit
Center-based	Center	RC 1 + audiologists	\$22.50/unit

Service	Location	Provider*	Rate (per 15 minute unit)
individual services		RC 2 + dietitians	\$16.49/unit
Consultation (child and family not present) - No travel involved	Any location but must be face-to-face	RC 1 + audiologists	\$22.50/unit
		RC 2 + dietitians	\$16.49/unit
Consultation (child and family not present) - Travel by provider required	Any location but must be face-to-face	RC 1 + audiologists	\$37.50/unit
		RC 2 + dietitians	\$27.50/unit

\* Reimbursement category 1 providers are physical therapists, occupational therapists, speech-language pathologists, nurses (registered nurses or nurse practitioners; providing nursing services or developmental services), physical therapist assistants and occupational therapy assistants. Reimbursement category 2 providers are certified therapeutic recreation specialists, counselors, educators, family and consumer science professionals, family therapists, music therapists, orientation and mobility specialists, psychologists, social workers, early intervention assistants, certified nursing aides and licensed practical nurses.

\*\* Includes center-based services with acceptable justifications AND for which travel by the provider is required. Such situations should be infrequent. Audiology and medical assessments are not required to occur in natural environments.

\*\*\* Medically necessary services from audiologists, dietitians, and physicians are reimbursed by Medicaid outside of the Medicaid Early Intervention Program. Providers are required to accept the Medicaid reimbursement as payment in full for these services.

#### Application of rates:

1. Services are reimbursed for the time spent directly with the child/family.
2. Providers may bill for their entire time spent in an IFSP meeting or assessment.
3. Providers are required to accept Medicaid reimbursement for medically necessary early intervention services as payment in full.
4. When the child is covered by private health insurance or has no insurance, the rate for a delivered service may be paid through multiple payor sources (private insurance, family fees, Part C funds, etc.). These payor sources and billing procedures are discussed below.
5. The entity that bills receives the standard EI rate. If the Local Lead Agency bills for the service, the local lead agency receives the EI rate and pays the employee or contractor who provided the services. Since the standard rates represent the total cost of providing a unit of service, including not only salary and benefit costs but also administrative and support costs such as billing and supervision, local lead agencies can negotiate with contracted providers regarding the portion or amount of the standard EI rate that will be "paid" to the local lead agency for doing the billing. For example, the standard EI rate for PT is \$150/hour. If ABC provider delivers 20 hours of PT services and is doing all of their own billing and supervision, then ABC provider will receive the \$150 rate multiplied by the number of PT hours provided. If, on the other hand, the local lead agency does all of the billing for ABC provider, then the local lead agency would negotiate with ABC provider to determine how much ABC provider will pay the local lead agency to do their billing. While the rate remains \$150/hour, the amount that the local lead agency will pay ABC provider for PT will be reduced by the amount the provider is paying the local lead agency for billing.



6. A provider will not be reimbursed for participation in consultations or IFSP meetings by phone.
7. For eligibility determination:
  - a. While eligibility determination does not have to be a face-to-face meeting, it must be planned ahead of time.
  - b. A provider may participate by phone, protected email, videoconference, etc. or a combination of those mechanisms to allow for review of available information and team interaction. Both the time spent for review/preparation and the time for team interaction are reimbursable.
  - c. No separate reimbursement is needed or appropriate if the provider participating in eligibility determination is a salaried employee of the local lead agency or if the eligibility determination is combined with the assessment for service planning (and the child is found eligible).

### Family Cost Share Practices

#### Local Lead Agency Responsibilities:

1. Identify the individual(s) who will be responsible for explaining the family cost share practices to families and assisting the family to complete the *Family Cost Share Agreement* form.
2. Ensure that the individual(s) who are responsible for implementing the family cost share practices are trained to:
  - a. Explain financial information, including use of Medicaid, TRICARE and private insurance for Part C early intervention services, availability of other resources to support Part C service provision, family fees and monthly caps; and
  - b. Collect and record the required financial information from families in a sensitive, confidential and accurate manner.
3. Ensure all families are advised that:
  - a. They must be charged the cost of care (i.e., full charge) to comply with federal Medicaid requirements that indicate all services must be charged in like manner; and
  - b. A sliding fee scale is available to reduce charges based on family size and income.

This and other critical aspects of the family cost share practices are explained in *Facts About Family Cost Share*, which is given to all families at the same time they receive *Notice and Consent to Determine Eligibility*.

4. Ensure billing for and collection of all family fees for the local Part C system. The local lead agency may: 1) do all billing and collection of family fees, 2) contract with a single entity to bill for and collect all family fees for the local Part C system, or 3) assign the billing and collection of the family fee to a specific agency/provider for each child.
5. Maintain and report quarterly to the State Lead Agency data on the total amount of family fees collected. Data must be on file at or accessible to the local lead agency and made available to the State Lead Agency, upon request, to document charges billed, payments received, and the status and follow-up for those families who are required to pay but do not do so.
6. Assist the family in accessing the Part C administrative complaint process, mediation and/or a due process hearing if disagreements regarding family cost share cannot be resolved.
7. Require providers to routinely (at least once a month) confirm with families whether or not their insurance has changed. The provider must notify the local system manager immediately if a child who has or had Medicaid/FAMIS no longer has Medicaid/FAMIS or does not have the Medicaid EI benefit, and notify the service coordinator if the child had

TRICARE or private insurance coverage and the child no longer has that coverage. For children with Medicaid, the following specific procedures apply. The Medicaid Early Intervention Services Manual, Chapter 3, states that eligibility for Medicaid benefits must be confirmed each time a service is rendered. While it is the provider's responsibility to verify Medicaid eligibility prior to every visit, changes in Medicaid eligibility tend to occur at the beginning or end of the month. An effective strategy is to verify Medicaid eligibility the first week of the month and after the 20<sup>th</sup> of the month. The provider must:

- a. Contact the Part C Office if the Medicaid EI benefit is not added within a week; and
- b. Retain documentation of all contacts with the Local System Manager and with the Part C Office as these will be used to determine the start date for adding (back) the Medicaid EI benefit.

Options for verifying a child's Medicaid/FAMIS coverage are discussed in the text box that follows, titled "Medicaid/FAMIS and Medicaid EI Benefit Eligibility Verification."

8. Ensure the following steps occur if notified by a provider that a child is not showing the Medicaid EI benefit:
  - a. The local system manager must:
    - Check to be sure that all information is entered correctly in ITOTS;
    - Notify the Part C Office immediately; and
    - Retain documentation of contacts with providers and with the Part C Office as these will be used to determine the start date for adding (back) the Medicaid EI benefit.
  - b. For a child who no longer has Medicaid/FAMIS coverage, the service coordinator must check with the family to determine if they are in the process of re-applying or if the child no longer meets the Medicaid/FAMIS financial eligibility requirements.
    - Approximately 20% of the Medicaid population loses their benefit for a variety of reasons, including failure to complete the re-application process. If the family is in the process of re-applying, then the service coordinator should:
      - Connect with the local Department of Social Services Office so the child's eligibility worker can assist the family with completion of the steps necessary to restore the benefit;
      - Contact the family weekly until the coverage is restored and notify the local system manager when the benefits are restored; and
      - Obtain information about the status of the application from the child's eligibility worker (DSS), if needed.
    - If the child is no longer financially eligible, the service coordinator must update the *Family Cost Share Agreement* form, and the Medicaid/FAMIS information must be deleted in ITOTS.
    - If the child's Medicaid/FAMIS coverage is not restored within 60 days of the date coverage ended, the Medicaid/FAMIS information must be deleted in ITOTS. If Medicaid/FAMIS coverage is later restored, Medicaid/FAMIS must be selected in ITOTS and the 12 digit number re-entered.

Medicaid/FAMIS and Medicaid EI Benefit Eligibility Verification:

There are several options for providers to use to verify Medicaid/FAMIS benefits, including the Medicaid Early Intervention benefits.

**Eligibility and Claims Status Information**

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. The website address to use to enroll for access to this system is <http://virginia.fhsc.com>.

**Eligibility Vendors**

DMAS has contracts with the following eligibility verification vendors offering Internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below.

Passport Health Communications, Inc. <a href="http://www.passporthealth.com">www.passporthealth.com</a> <a href="mailto:sales@passporthealth.com">sales@passporthealth.com</a> Telephone: 1-888-661-5657	SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX <a href="http://www.hdx.com">www.hdx.com</a> Telephone: 1-610-219- 2322	Emdeon <a href="http://www.emdeon.com">www.emdeon.com</a> Telephone: 1-877-363- 3666
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**Medicaid Medical Case Management Programs and Contacts**

A list of the contacts for the various Medicaid Managed Care Organizations can be found at: [http://www.dmas.virginia.gov/downloads/mcrguides/Chapter\\_9.pdf](http://www.dmas.virginia.gov/downloads/mcrguides/Chapter_9.pdf). Though early intervention services are “carved out” at this time, many of the infants and toddlers enrolled in Medicaid/FAMIS are enrolled in Managed Care. This list can be used by Service Coordinators in order to coordinate children’s other services with the Managed Care Organization. In addition, the MCO can assist with questions about the child’s Medicaid number and eligibility.

Responsibilities of the Individual(s) Designated to Implement Family Cost Share Practices for the Local Infant & Toddler Connection System:

1. **Conduct financial intake** following eligibility determination and prior to the initial IFSP meeting unless the child has Medicaid (in which case the *Family Cost Share Agreement* form must be completed prior to eligibility determination to ensure timely entry of Medicaid data into ITOTS and, as a result, Medicaid reimbursement for all reimbursable services).
  - a. Since the financial intake includes sharing personal financial information, care must be taken when combining eligibility determination and/or assessment for service planning and/or IFSP development to ensure the family has an opportunity for privacy during the financial intake.
    - If there is documentation from the physician of a qualifying diagnosed condition prior to the eligibility determination and the family wishes to combine the eligibility determination with the assessment for service planning, and potentially the IFSP meeting, then financial intake can be conducted prior to the combined activities.

- Otherwise, when eligibility determination and assessment for service planning are combined, then the financial intake should occur between assessment for service planning and the IFSP meeting. If the family wants the IFSP meeting also to occur on the same date, then the service coordinator needs to be sure the family understands (before consenting to this arrangement) that the financial intake will need to occur that day as well, prior to the IFSP meeting. The family should be made aware that if they wish to discuss these matters privately and if these activities are happening at the family's home, then there will need to be a separate place where the service coordinator and family can go to discuss the financial matters. Provider participants should also be made aware of the need to conduct financial intake during these combined activities since it impacts their time and availability for other activities and services.
- b. Under extraordinary circumstances, Part C funds may be utilized to ensure the timely provision of services until a monthly cap is determined through the family cost share practices. Any extenuating circumstances that result in the financial intake not being conducted prior to initiation of IFSP services must be clearly documented. In the event of such extraordinary circumstances, the family must provide income information within 30 calendar days of the parent signing the IFSP if they wish to access the fee scale. At the end of 30 days, if the family has not provided income information, then they have the option to either:
    - Sign the *Family Cost Share Agreement* form indicating that they will pay the full charge or marking the box "Opting to Delay Services" (indicating that they are choosing to delay further services, other than those available at no cost, until they can provide income information). If the family opts to delay services and those services have not yet started, this would be a family reason for a delay in start of services. Part C funds must be reimbursed once the monthly cap is established and payment is received. – OR-
    - Decline early intervention services
  - c. The financial intake must include providing families with the following:
    - A list of chargeable services as well as services for which there are no charges;
    - Charges and/or fees for the services;
    - Family Cost Share Agreement forms; and
    - A copy of the family cost share fee scale.
  - d. Financial intake also includes explaining the following:
    - No child and family will be denied services because of an inability to pay. The family cost share practices determine a family's ability to pay.
    - Families will be charged a monthly fee towards the full charge of their IFSP services unless they:
      - Have Medicaid (including FAMIS, FAMIS Plus, etc.). For families with FAMIS, Part C funds will be used to pay the family's co-pay for early intervention services listed on the child's IFSP;
      - Have an income that puts them at \$0 on the fee scale; or
      - Receive no services other than those that must be provided at no cost to families.

- The family fee covers all IFSP services, including assistive technology devices, regardless of the number, type, frequency or intensity of services provided.
- The family fee may not exceed the total of any applicable co-payments, deductibles, and/or the full early intervention reimbursement rate (if the service is not covered by insurance) for delivered IFSP services in a given month.

Background Information: How the family fee works for assistive technology devices

There is no separate fee to the family for assistive technology devices. The family's responsibility for payment toward the cost of such devices is covered by their use of insurance and/or the family fee just like all other IFSP services. (Note: Resources other than insurance also may be available to assist in the purchase of an assistive technology device. If available, these resources must be accessed prior to the use of Part C funds.)

An assistive technology device is considered a one-time cost that is incurred in the month of purchase. If the full charge for IFSP services other than the assistive technology device is less than the family's monthly cap, the family may pay a higher fee (up to the monthly cap) in the month the assistive technology device is purchased.

Example: Family's monthly cap is \$207. The child is receiving PT weekly and their insurance co-pay for each PT visit is \$25. Therefore, the family has been paying \$100/month. This month, the assistive technology device listed on the child's IFSP was purchased at a cost of \$500. Insurance did not reimburse for any of that cost. This month the family will pay not only the \$100 they've been paying for PT but also an additional \$107 toward the cost of the assistive technology device since this brings them up to their monthly cap of \$207.

- Families who will be charged a fee have the opportunity to provide documentation of taxable income that will be used along with family size to determine a monthly cap, or maximum amount, for their family fee, based on the family cost share fee scale. Because it's based on taxable income, the family cost share fee scale automatically takes into consideration normal living expenses, including medical costs associated with the child's disability.
- The monthly cap established by the family cost share fee scale is the same regardless of the number of children the family has enrolled in the Infant & Toddler Connection system at the same time (e.g., if the family's monthly cap is \$231 based on the fee scale, then that family pays no more than \$231 per month, total, regardless of the number of children in their family who are enrolled).
- If the family chooses not to provide income information then the family has declined to participate in the family cost share process.

- If the family has health insurance and agree to have it billed for reimbursable IFSP services, then they are required to pay all applicable co-payments and deductibles for those services.
    - If the family does not have health insurance, declines to have their insurance billed or the service is not covered by their health insurance, they must pay the full EI reimbursement rate for IFSP services.
  - Parent consent is required in order to bill private insurance for IFSP services. If the family does not provide consent to use their private insurance, the family pays the full EI reimbursement rate for IFSP services unless the family indicates that they believe use of their insurance will result in a financial loss such as a decrease in available lifetime coverage, escalation of premium, or discontinuation of the policy. As long as the necessary financial information is provided, the family cost share fee scale also can be accessed by families:
    - With insurance that does not cover early intervention services; or
    - Who do not have access to a provider in their insurer's network within the local Infant & Toddler Connection system.
  - Families that use their insurance as well as accessing the family cost share fee scale are responsible for covering the cost of insurance co-pays and deductibles up to the monthly cap. Part C funds may be used to cover the remaining balance of the co-pays and deductibles. Deductibles and co-pays are an obligation between the subscriber and the insurer, not the provider and the insurer. The provider agrees to collect the deductible and co-pay from the family, and these cannot be waived. Therefore, the full deductible/co-pay (minus the amount the parent pays that month) is the responsibility of Part C.
  - If the family feels the monthly cap calculated on the family cost share fee scale is more than they can afford, they may request to reduce the monthly cap through completion of the Fee Appeal Form. The fee appeal process is detailed later in this section.
  - In cases where services are anticipated to extend over one year, the family is informed that an annual re-evaluation of their financial circumstances is required.
2. Prior to development of the initial and each annual IFSP, complete the following steps to **determine the family cost share**:
- a. Determine whether the child is covered by Medicaid, TRICARE and/or private health insurance.
    - If so, review coverage opportunities with the family for Part C supports and services.
    - Request written parent consent on the *Family Cost Share Agreement* form to access Medicaid, TRICARE and/or private insurance for reimbursable Part C supports and services.
  - b. Determine the family's monthly cap using the family cost share fee scale. Request that the family provide proof of income by presenting (1) a copy or transcript of last year's federal 1040 tax returns; or (2) an estimated taxable income calculated by using the federal 1040 format (i.e., by completing a blank federal 1040 form, either the short form or the long form, from last tax year); or (3) if the family is unable to provide a copy of last year's tax return or estimated

taxes in accordance with (1) or (2) above, proof of net monthly income in accordance with steps outlined in the fee appeal process.

- Taxable income must be taken from the most recent federal 1040 tax return. Taxable income found on the state return may not be used.
- In situations where family conditions have materially changed since the most recently filed federal 1040 form, the family is required to notify their service coordinator. A revised taxable income will be determined by estimating taxable income using the 1040 format and using more current family financial data (i.e., by completing a blank federal 1040 form, either the short form or the long form), or by providing proof of net monthly income in accordance with the steps outlined in the fee appeal process.
- In situations where families have not retained copies of their most recent tax return, families should take two steps: (1) request a transcript of the most recently completed federal 1040 from the IRS (see note below); and (2) estimate their taxable income using the 1040 format and using more current family financial data (i.e., by completing a blank federal 1040 form, either the short form or the long form) for immediate use until the requested information is received. This will prevent a delay in the start of services. NOTE: Families are encouraged to request a transcript from the IRS and not a copy of their most recent tax return. Copies of tax returns cost approximately \$23 and can take several weeks to receive. Transcripts are sent at no cost within one to three weeks and can be requested by calling 1-800-829-1040 or accessing a request form (IRS Form 4506T) at [www.irs.gov](http://www.irs.gov).
- Completion of the federal 1040 form is the responsibility of the family and under no circumstances is it the responsibility of the individual designated by the local system to implement family cost share practices to assist the family in preparing estimated and/or annual income taxes.
- If the family's income level is low enough to make the family eligible for Medicaid or FAMIS, there is no family ability to pay and the monthly cap for the family fee is automatically assessed at zero (\$0). A family with income below the level that requires completion of federal income tax returns also has a monthly cap of zero (\$0) under the family cost share practices. To determine if a family's income is too low to require a tax return, visit [www.irs.gov](http://www.irs.gov)

3. **Complete the *Family Cost Share Agreement* form.** The *Family Cost Share Agreement* form is designed to clearly identify the specific responsibilities of the parent(s), document the choices parents have made regarding the manner in which they will pay for their services (i.e., use of insurance, full EI rate vs. monthly cap), identify the information used to determine the amount of the monthly cap, and obtain a written agreement from the parent(s) to pay for their early intervention services within their financial ability. If the family wishes to access the family cost share fee scale, then proof of income must be viewed by the individual designated by the local system to implement family cost share practices. Proof of income must be one of the following:
  - a. A copy of the family's most recent federal 1040 form (only the page showing taxable income); or
  - b. If the federal 1040 form is grossly misrepresentative of the current financial status (e.g., due to birth of new baby, change in employment or marital status, etc.) or is non-existent, an estimate of their taxable income using a blank federal 1040 form with current financial information filled in; or

- c. If no pay stub or income documentation of any kind exists, then a written statement from the employer verifying the net income amount; or
- d. If the family's income qualifies them for Medicaid/FAMIS, then documentation of Medicaid/FAMIS eligibility; or
- e. If the family states they have no income and no Medicaid/FAMIS and no proof of this is available, then a signed statement by the parent certifying that they have no income.

Visual regard of the income documentation is adequate verification of income, and it is not necessary under federal and state Part C requirements to retain a copy of the document viewed. Signatures on the *Family Cost Share Agreement* form of the parent and the individual reviewing the income documentation confirm that the required income documentation was viewed. Local agency or local system requirements may be different from the state practice that allows visual regard of income and expense documentation. The individual designated to implement the family cost share practices for the local Infant & Toddler Connection system must be aware of and comply with any local requirement to receive and maintain a copy of income and expense documentation. The *Family Cost Share Agreement* form must be maintained in the child's early intervention record or in a separate financial file. If the agreement form is filed in the early intervention record, it is recommended, but not required, that there be a separate section for financial information within the record, particularly for any information stored that documents the family's income or expenses.

4. **Ensure that re-evaluation of the family's cost share occurs at least annually** and whenever the family's financial circumstances change. Make sure the family knows to inform their service coordinator of any significant changes in their financial status, including a change in their insurance coverage, income, or family size, throughout enrollment in services unless the family has chosen to pay all applicable co-pays, deductibles and/or the full EI reimbursement rate (if the service is not covered by insurance) for IFSP services.
  - a. Once notified by the family of a change in the family's financial circumstances, the service coordinator facilitates completion of a revised *Family Cost Share Agreement* form that reflects the family's new financial circumstances. The revised *Family Cost Share Agreement* form is signed by the family. If there is a new monthly cap, it becomes effective on the date of signature on the *Family Cost Share Agreement* form.
  - b. Any delay in signing the *Family Cost Share Agreement* form annually must be handled the same as a delay in initially signing the form. Under extraordinary circumstances, Part C funds may be utilized to ensure the continued provision of services until the agreement form is signed. In the event of such extraordinary circumstances, the family must provide income information within 30 calendar days of the parent signing the annual IFSP if they wish to access the fee scale. At the end of 30 days, if the family has not provided income information, then they have the option to either:
    - Sign the *Family Cost Share Agreement* form indicating that they will pay the full charge or marking the box "Opting to Delay Services" (indicating that they are choosing to delay further services, other than those available at no cost, until they can provide income information). If the family opts to delay services and those services have not yet started, this would be a family reason for delay in the start of services. Part C funds must be reimbursed once the fee is established and payment received. – OR–
    - Decline early intervention services.



### Fee Appeal Process:

1. The intent of the fee appeal process is to provide families with the opportunity for individual consideration of financial circumstances including documentation of extraordinary expenses, such as medical or other expenses related to the child's disability, and to appeal for additional reduction of the monthly cap.
2. There should be no duplication of processes between the family cost share fee scale and the fee appeal process. If a family expresses financial hardship after the monthly cap is established using the family cost share fee scale and accesses the fee appeal process, the monthly cap established through the fee appeal process is the final determination of the family's monthly cap.
3. The following steps are used consistently with all families who access the fee appeal process:
  - a. Families are informed of all factors considered in the fee appeal process, including, but not limited to, the following:
    - The basis for the fee appeal is disposable income derived from taxable income (or net monthly income if the family is unable to provide actual or estimated taxable income) less actual expenses;
    - For items on the fee appeal form specifying a fixed average allowable amount (i.e., food, gasoline, clothing), no proof of expenses is needed unless the family's actual expenses exceed the average allowable amount. The fee appeal process specifies the following average allowable amounts:
      - ◆ Auto insurance - \$75 per month per family
      - ◆ Utilities - \$310 per month
      - ◆ Food - \$200 per person per month\*
      - ◆ Telephone - \$70 per month
      - ◆ Internet - \$20 per month
      - ◆ Cable - \$65 per month
      - ◆ Gasoline - \$100 per adult per month
      - ◆ Clothing - \$35 per person per month

The average allowable amounts may be exceeded only if the family provides documentation. The family is required to provide documentation of expenses for all items on the fee appeal form where an average allowable amount is not specified.

(\* This average amount includes the cost of groceries as well as the cost of eating some meals at restaurants.)

- The amount allowed for **recreation/entertainment** is limited to \$25 per person per month and may not exceed that amount.
- **Credit card payments** may be deducted for families carrying a credit card balance. Use the current minimum monthly payment amount or the documented monthly payment negotiated with the creditor, through a debt counseling service or court-ordered. This monthly amount does not need to be updated more than annually unless there is a significant change, which substantially impacts the family's ability to pay.
- **Educational expenses** include tuition, books, room and board and may be for any member of the family. Costs for programs like Gymboree classes or recreational programs may not be included as educational expenses.
- **Expenses to maintain the home in a livable condition** include expenses associated with adaptations necessary to make the home

- accessible and safe for a family member with a disability or to make repairs as a result of a natural disaster, fire or similar damage. Costs associated with a lawn service, weekly housecleaning service or remodeling for a purpose other than maintaining the home in a livable condition (e.g., cosmetic improvements) are not allowed.
- The category of **job-related necessities** includes expenses incurred when the wage earner must purchase job necessities that the employer does not furnish or reimburse, such as tools, equipment, materials or uniforms.
  - The following are not allowed as family monthly expenses on the fee appeal form: tithing; contributions to retirement or education savings accounts.
  - There is no “other” category under “Monthly Family Expenses.” If the family states an expense that does not fit into an existing expense category, contact Bev Crouse ([btcrouse@vt.edu](mailto:btcrouse@vt.edu) or 540-231-0803) who will determine either that the expense fits into a given category, can be added as an “other expense,” or cannot be deducted.
- b. The monthly cap is calculated by first subtracting expenses from taxable income (or net monthly income) and then taking 5% of that total. For example, if taxable income minus expenses equals \$100, then the monthly cap is 5% of \$100, which is \$5. Five percent (5%) of the disposable income is the amount determined as the monthly cap.
  - c. The *Fee Appeal Form* is completed and signed, and the family must provide documentation of their expenses as required by the *Fee Appeal Form*.
    - If using taxable income, the family will have already provided documentation of their taxable income in order to complete the *Family Cost Share Agreement* form. No further documentation of income is required. Divide the family’s taxable income by 12 and enter that amount on the “Monthly Family Income” line at the top of the *Fee Appeal Form*.
    - If using net monthly income, then enter this amount (based on pay stubs or written statement certifying income) on the “Monthly Family Income” line at the top of the *Fee Appeal Form*.
    - In situations where the family’s taxable or net monthly income puts them at \$0 on the family cost share fee scale, no documentation of expenses is required (because the family would already be at \$0 and showing further expenses would have no effect on the monthly cap amount).
  - d. Information on the monthly cap resulting from the fee appeal process is transferred to the *Family Cost Share Agreement* form.
4. A family’s inability to pay is different from a family’s unwillingness to pay. If a family has been given access to the family cost share fee scale and fee appeal process but is unwilling to pay for services that have been delivered, then providers may proceed with their own agency’s process for collecting delinquent accounts.
  5. If the family refuses to pay the fee determined through the fee appeal process, then the local system manager and service coordinator are notified. The service coordinator notifies all other service providers and provides a *Parental Prior Notice* form to the family indicating that all services, other than those that must be provided at no cost (e.g., service coordination, assessment, IFSP review) will not start or will end due to parent refusal to pay. The family must receive a copy and explanation of the *Notice of Child and Family Rights and Safeguards in the Infant & Toddler Connection of Virginia Part C Early Intervention System*. Even if the family has already received a copy of the Notice

of Child and Family Rights and Safeguards document, another copy must be offered. If the family has previously received a copy of the rights document and states that they do not want another copy, it is not necessary to leave another copy. A contact note must be used to document that another copy of the document was offered and that the family declined. In explaining the Notice of Child and Family Rights and Safeguards, the service coordinator reviews and explains the complaint procedures.

6. Parents have the right to access the administrative complaint, mediation and/or due process procedures if they disagree with assigned fees or other decisions related to family cost share.

## Billing Procedures

### General:

1. In order to be reimbursed, services must be provided in accordance with the IFSP. The frequency and intensity for a service cannot exceed that listed on the IFSP over a one month period unless the provider is making up missed sessions from another month.
2. With the exception of physicians, audiologists and registered dietitians, only certified early intervention providers and agencies who employ certified early intervention providers can bill for early intervention services.
3. Billing for early intervention services occurs at the local level. Each provider must have a mechanism to bill for services, either by:
  - a. Being employed by or contracted with an agency (including a local lead agency) that does the billing or contracts out the billing function; or
  - b. Doing their own billing.
3. Providers must have a National Provider Identifier, NPI, or Atypical Provider Identifier, API, for billing (group number if employed by an agency that is doing the billing, or an individual number if an independent practitioner). The National Provider Identifier is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard, a unique identification number for covered health care providers. An Atypical Provider is an individual or business that bills Medicaid for services rendered but does not meet the definition of a healthcare provider according to the NPI Final Rule 45CFR 160.103.

### Medicaid:

1. Under the Medicaid Early Intervention Services Program, providers bill Medicaid (for children with Medicaid fee for service, MCO or FAMIS coverage) using a CMS 1500 form and the codes listed in the Medicaid Early Intervention Services Program Reimbursement Information table at the end of this chapter.
2. Medically necessary audiology, nutrition, medical services and assistive technology devices are reimbursed by Medicaid outside of the Medicaid Early Intervention Services Program and require different codes.
3. In order to be reimbursed by Medicaid for early intervention services:
  - a. Providers must be EI Certified;
  - b. Providers must enroll with the Department of Medical Assistance Services (DMAS) as an early intervention provider, even if already enrolled as a rehab provider. Follow the instructions on the DMAS website ([www.dmas.virginia.gov](http://www.dmas.virginia.gov)) to enroll as an early intervention provider;
  - c. Services must be provided to children who are determined eligible for Part C services and who are receiving early intervention services, which may include an assessment for service planning, through the Infant & Toddler Connection system. Please see "Initial Data Entry for Enrollment in Medicaid EI Benefit" and

“Maintaining Enrollment in Medicaid EI Benefit” text boxes on the next two pages for specific information on the ITOTS information required for Part C eligible children who have Medicaid); and

- d. Services must be covered services and, with the exception of the assessment for service planning, approved by a physician, physician’s assistant or nurse practitioner (for specific requirements associated physician signature, please see the “Completing the IFSP Form” section of Chapter 7).

For additional information about early intervention services through the Medicaid Early Intervention Services Program, visit the DMAS website (see link above), click on the link to provider manuals, and then select Medicaid Early Intervention Services.

4. No service that is planned solely for the parent is reimbursable by Medicaid. However, if the child falls asleep during an intervention session, it is okay to provide teaching/coaching to the caregiver and to bill for this service. This situation should be infrequent and well-documented; and the length of the session will generally be shorter than planned since the provider and caregiver are not able to practice the strategies with the child.
5. Rounding the minutes of service provided up or down is not allowed. In cases where the provider does not complete one unit (15 minutes) of billing time, the provider may bill for a range of dates within a month (and the units provided in two or three sessions) that best captures the billable time. For instance, the provider delivers 55 minutes on 10/1, 50 minutes on 10/8, 40 minutes on 10/15, and 65 minutes on 10/22. The provider has delivered a total of 210 minutes of service and could bill this as  $210/15 = 14$  units for dates of service 10/1 – 10/22.
6. For children with Medicaid and commercial insurance coverage, providers must bill the commercial insurance first except in the following circumstances:
  - a. If a family has declined access to their private health/medical insurance for covered early intervention services because they believe use of their insurance will result in a financial loss such as a decrease in available lifetime coverage, escalation of premium, or discontinuation of the policy, then the following steps may be taken to secure Medicaid reimbursement without billing the commercial insurance first:
    - Check “yes” for box 11-D on the CMS 1500 form; and
    - Complete and sign a *Notification to the Department of Medical Assistance Services: Family Declining to Bill Private Insurance* form and attach it to the claim form.
  - b. Edits (requirements to submit proof of billing commercial insurance if the client has Medicaid as secondary) have been removed for the following billing codes: T1023 and T1023 UI; T1024 and T1024 U1; T1027 and T1027 U1; and T1015 and T1015 U1. This means providers do not have to go through the additional paperwork step of providing an explanation for why commercial insurance is not being billed or is not paying for developmental services and for assessments.
6. The local system manager (or designee) must check the monthly Medicaid Enrollment Report, Change Report and Claims Report and notify the Part C Office of any discrepancies between the Medicaid reports and the local information to ensure Medicaid EI enrollment and reimbursement are correct.

#### Initial Data Entry for Enrollment in Medicaid EI Benefit:

When the Department of Behavioral Health and Developmental Services (DBHDS) provides the Department of Medical Assistance Services (DMAS) with a list of children who are dually enrolled in Part C and in Medicaid, that data is pulled solely from the Medicaid line item in ITOTS under Third Party Health Coverage.

Therefore, in order for providers to receive Medicaid reimbursement for Part C early intervention services the following ITOTS data fields must be completed promptly and accurately:

- The check box next to Medicaid must be marked; and
- An accurate 12-digit Medicaid number must be entered in the ID field next to Medicaid. The 12-digit number is adequate documentation for DMAS to determine whether the child is enrolled in fee for service, FAMIS or an MCO.
- Eligibility Determination Completed is marked “yes”
- Date (of eligibility determination) is completed
- EI Eligible is marked “yes”

#### **Child has Medicaid/FAMIS when the Child is Referred to Part C**

- ITOTS data entry must be complete within 10 business days of the date for “eligibility determination completed” when EI Eligible is “yes” in order for the Medicaid/FAMIS Early Intervention benefit to start on the date of Assessment for Service Planning.
- If the required information is entered in ITOTS more than 10 business days after the date for “eligibility determination completed,” then the date the required information is entered in ITOTS will be the start date for the Medicaid Early Intervention benefit.

#### **Child Enrolled in Medicaid/FAMIS after the Child is referred to Part C**

- If Medicaid/FAMIS is selected and the 12-digit Medicaid number is entered in ITOTS within 30 calendar days of the date that the Medicaid/FAMIS eligibility was determined, then the start date for the Medicaid EI benefit is the same as the Medicaid/FAMIS start date, unless this date precedes the Part C Eligibility Determination date. If the Medicaid/FAMIS start date precedes the Part C Eligibility Determination Date, then the Part C Eligibility Determination Date will be the start date for the Medicaid EI benefit.
- If Medicaid/FAMIS is selected and the 12-digit Medicaid number is entered more than 30 calendar days after the date that the Medicaid/FAMIS eligibility was determined, then the date the required information was entered in ITOTS will be the start date for the Medicaid EI benefit. Neither Medicaid nor Part C reimbursement will be available for the time period that is not covered.

### Maintaining Enrollment in Medicaid EI Benefit:

#### **Child's Medicaid Early Intervention Benefit is "Dropped" in the Medicaid MMIS System:**

- Occasionally, a child's EI benefit in the Medicaid MMIS system may be dropped, which can occur when the child has changes in their Medicaid/FAMIS benefits. If this happens, the local system must notify the Part C office in order for the EI benefit to be added back to the Medicaid MMIS system starting the next day from when the benefit had ended.

#### **Child Loses Medicaid/FAMIS Coverage, Then Coverage is Restored:**

- The local system must notify the Part C Office within 30 calendar days of restoration of the child's Medicaid/FAMIS coverage. When the local system meets this timeline, the date the Medicaid/FAMIS is restored will be the start date for restoration of the Medicaid EI benefit.
- If the local system notifies the Part C Office more than 30 calendar days after the date Medicaid/FAMIS is restored, then the date the local system notifies the Part C Office will be the start date for the Medicaid EI benefit and reimbursement will not be available through Medicaid or Part C for the time period that is not covered.
- If the child lost Medicaid/FAMIS coverage for more than 60 days and the Medicaid/FAMIS information was deleted from ITOTS, the local system must re-enter the Medicaid/FAMIS information in ITOTS within 30 calendar days of the date Medicaid/FAMIS is restored.

#### **Child is Transferred from One Local System to Another Local System in Virginia:**

- The "sending" local system must complete the discharge data entry, including transferring the record to the new ("receiving") local system prior to the date that the child will be starting services within the new local system.
- When a child transfers from one local system to another, the start date for the Medicaid EI benefit under the new, "receiving" local system must be after the discharge date from the original, "sending" local system.
- There must not be two open records in ITOTS for the same child.

#### **Child Becomes Inactive**

- When a child becomes inactive, this must be documented in ITOTS within 10 days of the inactive date.

#### **Child Becomes Active after Being Inactive**

- For children who become active after being inactive, the local system must make the child active again in ITOTS **AND** must notify the Part C Office within 10 business days of the date that the child becomes active again so that the EI benefit can be added back into the Medicaid MMIS system using the date the child became active as the start date for the EI benefit. Notification to the Part C Office is necessary because the ITOTS system does not currently capture the date the child becomes active after being inactive.
- If the local system notifies the Part C Office more than 10 business days after the child becomes active, the date the local system notifies the Part C Office will be the start date for the Medicaid EI benefit.

## Private Insurance and TRICARE

1. Providers bill third party payors according to the requirements (including billing codes and forms) of the particular payor.
2. Virginia has enacted third party payor regulations that mandate coverage for early intervention services. Insurance companies that are domiciled in Virginia and that are part of the fully insured market must include coverage for physical therapy, occupational therapy, speech-language therapy and assistive technology for infants and toddlers enrolled in the Infant & Toddler Connection of Virginia.
  - a. The benefit is capped at \$5,000 per year.
  - b. The mandate specifies that money paid through this benefit cannot be applied to the insured's lifetime maximum benefit.
  - c. Organizations who contract with insurance companies to manage their employee health benefits, but who "self-fund" the benefit are exempt from the mandate.
  - d. A similar mandate is included for insurance for state employees.Insurance companies based outside of Virginia (even if operating and covering services provided in Virginia) as well as self-insured policies are not covered by the early intervention insurance mandate. For more information on these insurance mandates click on <http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+38.2-3418.5> and <http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+2.2-2818>.
3. Private insurance plans may not be billed for services where no consumer liability can be established (i.e., where services must be provided at no cost to the family).
4. TRICARE is the uniformed services health care program for active duty service members and their families, retired service members and their families, members of the National Guard/Reserve and their families, survivors and other eligible beneficiaries. TRICARE is a public third party payor. As such, TRICARE can be billed for assessments conducted under Part C (whereas, private insurance cannot). To learn more about TRICARE, including information about the managed care support contractor for TRICARE North Region, which includes Virginia, click on [www.tricare.mil](http://www.tricare.mil).
5. Since private insurance companies typically do not reimburse for the increased costs incurred when services are provided in natural environments, Part C funds are used to bring the reimbursement to the provider up to the standard early intervention rate or up to the rate charged by the provider, whichever is less.

## Part C Funds

1. In order to receive Part C reimbursement as the payor of last resort (e.g., for services not covered by third party payors or to bring provider reimbursement up to the standard rate), providers must have a contractual relationship with the local Infant & Toddler Connection system.
2. Providers are required to submit a contact log or contact notes to the local lead agency no later than the 21st of each month for the previous month for all services provided, including any service for which reimbursement is sought from Part C funds.
  - a. Local lead agencies may decide to require all providers to submit only contact logs or only contact notes or may allow each provider the choice of submitting either the log or notes.
  - b. When submitting a contact log, the log must include the type of service delivered (e.g., physical therapy, developmental services, OT, etc.), date(s) of service delivery, amount of time service was provided on each date, and signature of the provider or an authorized individual from the provider's agency.

- c. When insurance reimbursement is pending for a service, include that service on the log for the month in which the service was delivered and mark it “insurance pending.” Once the insurance company has acted, if Part C funds are being requested, then submit that service again on a later log for payment by Part C.
- 3. Part C funds cannot be used to reimburse a provider for a Medicaid billable service when the child has Medicaid, except when necessary to prevent a delay in the timely start of services. Once Medicaid funds are received they must be used to reimburse the local system for the Part C funds originally paid. For example, suppose a family is in the process of applying for Medicaid when a Part C service begins on March 16. The child’s Medicaid eligibility is established on April 1 and coverage is backdated to March 1. If Part C funds were used to pay the provider for the service delivered on March 16, then Medicaid must be billed for that service and the local system must be reimbursed for the Part C funds originally used to pay for that service.
- 4. Sample billing and reimbursement scenarios are provided on the next page to illustrate use of Part C funds as payor of last resort when the family allows their private insurance to be billed for Part C services.

#### Purchase of Assistive Technology Devices

- 1. Public procurement policies must be followed when using public funds to pay for all or part of an assistive technology device.
- 2. If purchased with the family’s health insurance (public or private), the equipment belongs to the family and they may keep it when they leave the Infant & Toddler Connection of Virginia system.
- 3. If federal or state Part C funds are used to pay for more than 50% of an assistive technology device and the device is valued at \$5,000 or more, then the assistive technology device belongs to the local Infant & Toddler Connection system and must be treated as follows when the child leaves the system:
  - a. The assistive technology device is returned to the local Infant & Toddler Connection system, re-inventoried and used for other children on a loaner or a trial basis.
  - b. If the child is transitioning to preschool special education services under Part B through the local school division, then the local school system may receive the assistive technology device and utilize it as long as the child needs it. Once the child no longer needs the device, it is returned to the local Infant & Toddler Connection system.
  - c. If the child is transitioning to a program other than preschool special education services under Part B, then the receiving program may purchase the assistive technology device with appropriate depreciation consideration.
- 4. Assistive technology devices that are expendable, personal use items (e.g., bath forms, ear molds) are for the personal use of the specific child and are not reclaimed.
- 5. The Local Lead Agency must maintain a comprehensive, up-to-date inventory of all assistive technology devices purchased with federal or state Part C funds paying more than 50% of the cost and valued at \$5,000 or more. This inventory will cite the device, appropriate serial numbers, location of the device, and anticipated disposition of the device including timeline.
- 6. Please see the text box titled “When considering the purchase of an Assistive Technology Device” in “The Initial IFSP Meeting” section of Chapter 7 for information about what is considered an assistive technology device under Part C.



## Sample Billing/Reimbursement Scenarios:

Family Cost Share Agreement Form Says:	Charges and Reimbursement
1. Private insurance (w/permission to bill) Full fee	Provider Charge: \$180 Insurance Co-Pay: \$20 Insurance Deductible: \$500 Insurance Allows: \$95 Amount applied to deductible: \$0  Part C Standard Rate: \$150 Insurance Pays: \$95 Family Pays: \$20 Part C Pays: \$35
2. Private insurance (w/permission to bill) Fee Cap = \$0	Provider Charge: \$180 Insurance Co-Pay: \$25 Insurance Deductible: \$1,000 Insurance Allows: \$90 Amount applied to deductible: \$0  Part C Standard Rate: \$150 Insurance Pays: \$90 Family Pays: \$0 Part C Pays: \$60
3. Private insurance (w/permission to bill) Family has PPO allowing balance billing Fee Cap = \$0	Provider Charge: \$180 Insurance Co-Pay: \$0 Insurance Deductible: \$1,000 Insurance Allows: \$80.50 Amount applied to deductible: \$80.50  Part C Standard Rate: \$150 Insurance Pays: \$0 Family Pays: \$0 Part C Pays: \$150
4. Private insurance (w/permission to bill) Fee Cap = \$0	Provider Charge: \$180 Insurance Co-Pay: \$25 Insurance Deductible: \$1,000 Insurance Allows: \$180 Amount applied to deductible: \$180 (co-pay amount included in deductible)  Part C Standard Rate: \$150 Insurance Pays: \$0 Family Pays: \$0 Part C Pays: \$180*

\* Deductibles and co-payments cannot be bound by the contract rate that the Part C system has with a private agency for direct services that are not covered by insurance since the insurance reimbursement rates and co-payment and deductible amounts are determined and set by the insurer. Deductibles and co-payments are an obligation between the subscriber (family) and the insurer, not the provider and the insurer. The provider agrees to collect the deductible and co-payment from the family. These cannot be waived. Therefore, the full deductible and co-payment (minus the amount the parent pays that month) is the responsibility of Part C.

## Reimbursement Sources and Medicaid EI Codes for Components of the Early Intervention Process for Children with Medicaid or FAMIS Coverage

Step			90 Day TCM*	Medicaid TCM*	Medicaid EI	Medicaid EI Codes	Other Medicaid	Other Funds**	Part C – POLR
<b>Referral Steps</b>			X	X				X***	X***
<b>Intake</b>			X	X				X***	X***
<b>Developmental Screening</b>			X	X				X***	X***
<b>Hearing and Vision Screening</b>			X	X				X***	X***
<b>Eligibility Determination</b>	<b>SC</b>		X	X				X***	X***
	<b>EIP</b>							X***	X***
<b>Assessment for Eligibility</b>	<b>SC</b>		X	X				X***	X***
	<b>EIP– Child found eligible</b>	<b>PT, OT, SLP, N</b>			X	T1023 U1			
		<b>Other EIP</b>			X	T1023			
	<b>EIP – Child found not eligible</b>							X	X
<b>Assessment for Service Planning</b>	<b>SC</b>			X				X	X
	<b>EIP</b>	<b>PT, OT, SLP, N</b>			X	T1023 U1			
		<b>Others</b>			X	T1023			
<b>IFSP Development</b>	<b>SC</b>			X				X	X
	<b>EIP: PT, PTA, OT, OTA, SLP, N</b>				X	T1023 U1			
	<b>EIP: Other EIP and EIS</b>				X	T1023			
<b>Provide Individual EI Services in Natural Environments</b>	<b>EIP: PT, PTA, OT, OTA, SLP, N</b>				X	G0151 U1 G0152 U1 G0153 U1 G0154 U1			
	<b>EIP: ECE, etc</b>				X	T1027 & T1027 U1			
	<b>Other Disc: AUD, Diet., etc.</b>						X	X	X
	<b>EIS: EIA, Nurse Aide</b>				X	T1027 & T1027 U1			
<b>Provide Group EI Services in Natural Environments</b>	<b>EIP: PT, PTA, OT, OTA, SLP, N</b>				X	G0151,G0152, G0153,G0154			
	<b>EIP: ECE, etc</b>				X	T1027			
	<b>Other Disc: AUD, Diet., etc.</b>						X	X	X
	<b>EIS: EIA, Nurse Aide</b>				X	T1027			
<b>Provide Individual EI Services Center</b>	<b>EIP: PT, PTA, OT, OTA, SLP, N</b>				X	T1026 U1			
	<b>EIP: ECE, etc</b>				X	T1015 U1			
	<b>Other Disc: AUD, Diet., etc.</b>						X	X	X
	<b>EIS: EIA, Nurse Aide</b>				X	T1015 U1			
<b>Provide Group EI Services in Center Setting</b>	<b>EIP: PT, PTA, OT, OTA, SLP, N</b>				X				
	<b>EIP: ECE, etc</b>				X	T1015			
	<b>Other Disc: AUD, Diet., etc.</b>						X	X	X
	<b>EIS: EIA, Nurse Aide</b>				X	T1015			
<b>IFSP Review Meeting: Child and family</b>	<b>EIP: PT, PTA, OT, OTA, SLP, N</b>				X	T1024 U1			
	<b>EIP: Others and EIS</b>				X	T1024			

Step		90 Day TCM*	Medicaid TCM*	Medicaid EI	Medicaid EI Codes	Other Medicaid	Other Funds**	Part C – POLR
present								
Consultation: without child/family	EIP and EIS						X	X

**PLEASE NOTE that Federal Regulations and Virginia Policies and Procedures require that ....no services that a child is entitled to receive are delayed or denied because of disputes between agencies regarding financial or other responsibilities.**

**Key:** \* For Children who Meet Medicaid TCM Eligibility Criteria  
 \*\* State and local non-Part C funds, grants, donations, etc.  
 \*\*\* For children who do not meet either MH or MR TCM criteria  
**POLR** Payor of Last Resort  
**AUD** Audiologist  
**Diet** Dietitian  
**ECE** Early Childhood Educator  
**EIP** Early Intervention Professional (PT, OT, ECSE, etc.)  
**EIS** Early Intervention Specialist (PT Assistant, OT Assistant, Early Intervention Assistant, Nurse Aide)  
**Others** Early Intervention Professionals other than OT, PT, SLP and Registered Nurses and Nurse Practitioners  
**SC** Service Coordinators  
**TCM** Targeted Case Management

## Reimbursement Sources for Components of the Early Intervention Process for Children with Tricare, Private Insurance or No Third Party Payor Source

Step			TRICARE	Private Insurance	Other Funds**	Part C - POLR
Referral Steps					X	X
Intake					X	X
Developmental Screening					X	X
Hearing and Vision Screening					X	X
Eligibility Determination	SC				X	X
	EIP				X	X
Assessment for Eligibility	SC				X	X
	EIP – Child found eligible	PT, OT, SLP, N	X		X	X
		Other EIP			X	X
	EIP – Child found not eligible		X		X	X
Assessment for Service Planning	SC				X	X
	EIP	PT, OT, SLP, N	X		X	X
		Other EIP			X	X
IFSP Development	SC				X	X
	EIP: PT, PTA, OT, OTA, SLP, N				X	X
	EIP: Others and EIS				X	X
Provide Individual EI Services in Natural Environments	EIP: PT, PTA, OT, OTA, SLP, N		X	X	X	X
	EIP: ECE, etc				X	X
	Other Disc: AUD, Diet., etc.		X***	X***	X	X
	EIS: EIA, Nurse Aide				X	X
Provide Group EI Services in Natural Environments	EIP: PT, PTA, OT, OTA, SLP, N		X	X	X	X
	EIP: ECE, etc				X	X
	EIS: EIA, Nurse Aide				X	X
Provide Individual EI Services Center	EIP: PT, PTA, OT, OTA, SLP, N		X	X	X	X
	EIP: ECE, etc				X	X
	Other Disc: AUD, Diet., etc.		X***	X***	X	X
	EIS: EIA, Nurse Aide				X	X
Provide Group EI Services in Center Setting	EIP: PT, PTA, OT, OTA, SLP, N		X	X	X	X
	EIP: ECE, etc				X	X
	EIS: EIA, Nurse Aide				X	X
IFSP Review Meeting: Child and family present	EIP: PT, PTA, OT, OTA, SLP, N				X	X
	Other EIP and EIS				X	X
Consultation: without child/family	EIP and EIS				X	X

**Key:** \*\* State and local non-Part C funds, grants, donations, etc.

**POLR** Payor of Last Resort      **AUD** Audiologist      **Diet** Dietitian      **SC** Service Coordinators

**ECE** Early Childhood Educator      **EIP** Early Intervention Professional (PT, OT, ECSE, etc.)

**EIS** Early Intervention Specialist (PT Assistant, OT Assistant, Early Intervention Assistant, Nurse Aide)

**Other EIP:** Early Intervention Professionals other than OT, PT, SLP and Registered Nurses and Nurse Practitioners

## Medicaid Early Intervention Services Program Reimbursement Information

Code	Rate	Who bills	When is This Used	Location	Limits
T1023	27.50/unit	Reimbursement Category 2 Providers	<ul style="list-style-type: none"><li>Initial Assessment for Service Planning</li><li>Development of IFSP</li><li>Annual IFSP</li></ul>	NE or Center-based	24 units/day and 36 units/year
T1023 U1	37.50/unit	Reimbursement Category 1 Providers			
T1024	27.50/unit	Reimbursement Category 2 Providers	<ul style="list-style-type: none"><li>Team Treatment activities (more than one professional providing services during same session for an individual child/family)</li><li>IFSP Review Meetings (must be in person)</li><li>Assessments that are done <u>after</u> the initial Assessment for Service Planning</li></ul>	Natural Environments*	The maximum daily units/per child/ per (service) code/ per individual provider is <b>6 units</b> with a maximum of <b>18 units</b> (for any combination of codes) per day per child for all providers combined.  [The 18 units can be a combination from 2 or more agencies/providers or can be all from one agency as long as no individual provider exceeds the 6 units/individual provider/per day limit]
T1024 U1	37.50/unit	Reimbursement Category 1 Providers			
T1027	18.43/unit	Reimbursement Category 2 Providers	<ul style="list-style-type: none"><li>Developmental Services and other early intervention services provided for more than one child by one Early Intervention Certified Specialist (congregate), except PTA or OTA</li></ul>	Natural Environments*	
T1027 U1	27.50/unit		<ul style="list-style-type: none"><li>Developmental Services and other early intervention services provided for one child by one Early Intervention Certified Specialist, except PTA or OTA</li></ul>		
T1026	7.43/unit	Reimbursement Category 1 Providers	<ul style="list-style-type: none"><li>Center-based group early intervention services</li></ul>	Center-based	
T1026 U1	22.50/unit		<ul style="list-style-type: none"><li>Center-based individual early intervention services</li></ul>	Center-based	
T1015	5.44/unit	Reimbursement Category 2 Providers	<ul style="list-style-type: none"><li>Center-based group early intervention services</li></ul>	Center-based	
T1015U1	16.49/unit		<ul style="list-style-type: none"><li>Center-based individual early intervention services</li></ul>	Center-based	
G0151	25.13/unit	Physical Therapists, PTAs (RC 1)	<ul style="list-style-type: none"><li>Congregate PT</li></ul>	Natural Environments*	
G0151 U1	37.50/unit		<ul style="list-style-type: none"><li>Individual PT</li></ul>		
G0152	25.13/unit	Occupational Therapists, OTAs (RC 1)	<ul style="list-style-type: none"><li>Congregate OT</li></ul>	Natural Environments*	
G0152 U1	37.50/unit		<ul style="list-style-type: none"><li>Individual OT</li></ul>		
G0153	25.13/unit	Speech Language Therapists (RC 1)	<ul style="list-style-type: none"><li>Congregate SLP</li></ul>	Natural Environments*	
G0153 U1	37.50/unit		<ul style="list-style-type: none"><li>Individual SLP</li></ul>		
G0154	25.13/unit	RN or RNP (RC 1)	<ul style="list-style-type: none"><li>Congregate Nursing Services</li></ul>	Natural Environments*	
G0154 U1	37.50/unit		<ul style="list-style-type: none"><li>Individual Nursing Services</li></ul>		

\* May include rare situations where services are provided in a center with acceptable justifications **AND** for which travel by the provider is required. See Infant & Toddler Connection of Virginia Practice Manual for information.

## Chapter 12: Personnel

### Practitioner Qualifications

1. Personnel providing Part C early intervention supports and services in Virginia must meet the discipline-specific qualifications specified in Table A at the end of this chapter.
2. Individual practitioners of early intervention services, except physicians, audiologists and registered dietitians, must be certified by the State Lead Agency as an Early Intervention Professional, Early Intervention Specialist, or Early Intervention Service Coordinator. Audiologists who provide Part C services other than audiological testing are strongly encouraged to become certified as Early Intervention Professionals.
3. In order to provide both service coordination and another early intervention service, a practitioner must be certified as both an Early Intervention Professional and an Early Intervention Service Coordinator or as both an Early Intervention Specialist and an Early Intervention Service Coordinator.

### Scope of Practice

1. Qualified practitioners have those responsibilities designated in Table A.
2. Certified Early Intervention Specialists must work under the supervision of an Early Intervention Professional who has completed the Infant & Toddler Connection of Virginia supervision training module and passed the competency test with at least 80% accuracy. Early Intervention Specialists may be supervised by an Early Intervention Professional from any discipline unless discipline-specific regulations specify otherwise.
3. Certified Early Intervention Service Coordinators who have completed the supervision training module may supervise other service coordinators only.

### Early Intervention Certification

There are three early intervention certifications: Early Intervention Professional, Early Intervention Specialist, and Early Intervention Service Coordinator. Certifications are granted for a three-year period.

#### Requirements and Process for Initial Certification:

1. Practitioners interested in providing early intervention services in the Infant & Toddler Connection of Virginia system complete an online application that can be found on the Infant & Toddler Connection of Virginia website at <https://www.eicert.dbhds.virginia.gov>. A *Practitioner Application Manual* is also available on the website at <http://www.infantva.org/documents/ei-Cert-usermanual.pdf> to assist applicants. The applicant must:
  - a. Meet the discipline-specific licensure/certification requirements that apply to his/her discipline; and
  - b. Complete the following Infant & Toddler Connection of Virginia online training modules, passing the competency test for each with at least 80% accuracy:
    - Child Development
    - Family Centered Practices
    - Service Pathway
    - Practitioner Requirements; and
  - c. Signify agreement with the assurances on the application, indicating that he/she has knowledge of and agrees to abide by federal and state regulations and the

practices specified in the *Infant & Toddler Connection of Virginia Practice Manual*.

2. Once the online application is submitted, the applicant will receive a confirmation on the computer screen and in an email that the application has been submitted. If the applicant cancels his/her application before submitting it, a notice on the screen will confirm the cancellation.
3. The applicant is notified of the status of his/her application:
  - a. If the applicant has met all certification requirements, then the applicant receives notification that certification is granted.
  - b. If the application is incomplete, then the applicant receives notification that it is necessary to provide the missing information.
  - c. If the applicant does not meet all certification requirements, then the applicant receives notification that the request for certification is denied.
4. All certified practitioners are listed in the Infant & Toddler Connection of Virginia practitioner database, which is maintained by the State Lead Agency. The database will include the practitioner's name, discipline, licensure and certification information, and contact information (which can include not only the practitioner's direct phone number and email address but also the name and contact information of the agency with which the practitioner is employed).

#### Requirements and Process for Recertification:

1. Practitioners interested in renewing their certification to provide early intervention services in the Infant & Toddler Connection of Virginia system complete an online application that can be found on the Infant & Toddler Connection of Virginia website at <https://www.eicert.dbhds.virginia.gov> at least 30 business days before their current certification expires. The applicant must:
  - a. Meet the discipline-specific licensure/certification requirements that apply to his/her discipline;
  - b. Complete 30 hours of training over the 3-year certification period with content that addresses one or more of the following and is applicable to early intervention:
    - Evidence based practices
    - Changes in policies, procedures and practices
    - Topics identified on the practitioner's professional development plan (see Responsibilities of Certified Practitioners section below for more information on professional development plans); and
    - Training needed for new responsibilities.
  - c. Complete Kaleidoscope Level I and Level II training within 18 months of initial certification as an Early Intervention Service Coordinator unless the applicant completed this training prior to certification. The Kaleidoscope training counts towards the 30 hours of training required for the practitioner's first recertification.
  - d. Signify agreement with the assurances on the application, indicating that he/she has knowledge of and agrees to abide by federal and state regulations and the practices specified in the *Infant & Toddler Connection of Virginia Practice Manual*.
2. Once the online application is submitted, the applicant will receive a confirmation on the computer screen and in an email that the application has been submitted. If the applicant cancels his/her application before submitting it, a notice on the screen will confirm the cancellation.
3. The applicant is notified of the status of his/her application:

- a. If the applicant has met all certification requirements, then the applicant receives notification that the certification is granted.
- b. If the application is incomplete, then the applicant receives notification that it is necessary to provide the missing information.
- c. If the applicant does not meet all certification requirements, then the applicant receives notification that the request for certification is denied.

#### Lapsed Certification

1. If the practitioner's certification expires, the State Lead Agency will notify the practitioner in writing of the date his/her certification as an early intervention professional, early intervention specialist or early intervention service coordinator expired and that the practitioner has been placed on inactive status (i.e., is no longer included on search lists) in the practitioner database.
2. A practitioner with a lapsed certification may neither provide nor bill (Part C or Medicaid) for early intervention services until his/her certification has been restored.

#### Restoration of Lapsed Certification:

1. The State Lead Agency may restore an expired certification under the following conditions and with the following documentation from the practitioner:
  - a. The individuals' certification has lapsed for a period less than one year; and
  - b. The certification has lapsed because:
    - The practitioner failed to complete the three-year recertification requirements and the individual provides documentation to the State Lead Agency demonstrating (i) he/she meets the discipline-specific licensure/certification requirements that apply to his/her discipline, and (ii) he/she has completed at least 30 hours of training related to evidence-based practices in early intervention; changes in policies, procedures and practices; topics identified on the practitioner's professional development plan; or training needed for new responsibilities; or
    - The practitioner's discipline-specific qualifications expired and the practitioner documents that he/she now holds a current license, certification, endorsement, or other qualification for the practice of his/her discipline or profession in the Commonwealth of Virginia.
2. When a practitioner's certification is restored, he/she is restored to active status in the practitioner database.

#### Termination of Certification:

1. A practitioner's early intervention certification will be terminated if:
  - a. The practitioner's discipline-specific license, certification, or endorsement has been suspended or terminated; or
  - b. The practitioner, after a year of having a lapsed certification, fails to comply with the recertification requirements; or
  - c. The practitioner fails to comply with the signed assurances.

#### Procedures for Reconsideration of Decision to Deny or Terminate Certification:

1. If a practitioner disagrees with the decision to deny or terminate certification, he/she may request reconsideration by the commissioner of the State Lead Agency. The request must be made in writing within 30 days of the date of the written notice of denial or



termination and may include relevant additional information or documentation to support the request.

2. The commissioner will review the request for reconsideration and information presented and will issue a decision in writing within 30 business days following receipt of the request. The decision of the commissioner is a final case decision that may be appealed under the Virginia Administrative Process Act.

#### Responsibilities of Certified Practitioners

1. Maintain a Professional Development Plan – This requirement recognizes the individualized nature of the training and experience of individuals providing early intervention services and provides a mechanism for individuals to customize their continuing education to meet their specific needs. Each practitioner is responsible for maintaining a copy of her/his own professional development plan and for making that available to the local system manager and the State Lead Agency upon request.
  - a. Practitioners may use the *Early Intervention Individual Professional Development Plan* form available at <http://www.infantva.org/Pr-PracticeManual-Forms.htm> or may use an alternate form provided through their agency.
  - b. Practitioners who work independently, rather than for an agency, must have their plan reviewed and signed by the local system manager in at least one of the local Infant & Toddler Connection systems in which they work.

The professional development plan is fluid and can change over the 3-year period to reflect emerging/changing needs.

2. Complete 30 hours of training every 3 years that meets the certification requirements specified above.
  - a. What Constitutes a Training Activity: In order to count toward the required hours for recertification, a training activity must be at least 2 hours in length. These 2 hours do not have to be consecutive, and a training activity can include a planned combination of activities that total two or more hours. For instance, a practitioner whose professional development plan indicates the need to expand her skills in evidence-based practices related to feeding might participate in a 1-hour feeding workshop and then spend an hour with a mentor practicing the skills taught during the workshop. These two pieces together make 1 training activity of at least 2 hours that counts towards the 30 hours of training for recertification.
  - b. Training Opportunities: The State Lead Agency provides information to local systems and practitioners about available training opportunities that have been made known to the Part C office, which include a mix of trainings that are free and those that require a fee. It is expected that practitioners will also investigate additional available training opportunities. Most, if not all of the training required to maintain Part C certification also will meet discipline-specific continuing education requirements.
  - c. Documentation of Completed Training: For each training activity, documentation maintained by the practitioner must include a description of the activity and sponsoring organization, if applicable; the date or dates of training; the number of hours; and a copy of a certificate or verification of attendance, if applicable. Practitioners are required to retain documentation of successful completion of the 30-hour training requirement for recertification for three years following issuance of the renewal certification (i.e., until the issuance of their next renewal certification). That documentation must be made available to the State Lead Agency upon request.
  - d. Types of Training Allowed: The table following this section specifies the categories of training activities that may be completed as part of the 30 hours of

training required for recertification. Following the table is a text box that addresses Frequently Asked Questions about what counts and what does not count as training for Part C recertification.

3. Complete the *Early Intervention Training Record* form, which is available along with a sample, partially-completed form at <http://www.infantva.org/Pr-PracticeManual-Forms.htm>. Practitioners must use this form to track the professional development activities completed during each 3-year certification cycle and submit the completed form with their recertification application.
  - a. The practitioner's supervisor must sign off on each line of the training record to indicate his/her awareness of the trainings/activities the employee is accessing as well as approval of the activities.
  - b. Independent practitioners who practice without a supervisor are required to obtain the initials of the local system manager in at least one of the local Infant & Toddler Connection systems in which they work.
4. Ensure the correct and current discipline-specific licensure information is listed in the online Early Intervention Certification (EICERT) module, updating the expiration date for each qualification (license), as needed, to match the date on the most current license. For more specific instructions, practitioners can go to the EICERT website (<https://www.eicert.dbhds.virginia.gov>) and click on the User Manual link at the top of the left menu.
5. Immediately notify the State Lead Agency of any change that may affect their certification status or their participation in the Infant & Toddler Connection of Virginia.

#### Types of Training Allowed

Training Category	Description	Hours	Documentation Required
College courses	<ul style="list-style-type: none"> <li>Must be earned at a regionally accredited 2-year or 4-year college;</li> <li>Must be taken for credit;</li> <li>Must earn passing grade;</li> <li>Could be pass-fail.</li> </ul>	1 semester hour = 10 hours	Transcript
Professional development activities	<ul style="list-style-type: none"> <li>Self-study: online; journal; book group; may be group or individual.</li> <li>Mentoring</li> <li>Online training</li> <li>Inservice training: Examples include a training within the practitioner's own agency; attending a meeting with speaker (only the time when the speaker is presenting counts as training); a brown bag lunch series; etc.</li> </ul>	<p>Hours based on amount of time spent (1 hour spent = 1 hour)</p> <p><b>Maximum of 5 hours of training per 3-year period may be self-study</b></p>	<ul style="list-style-type: none"> <li>Self-study: Written summary of what was done, amount of time spent, sources used</li> <li>Mentoring: Written summary of activities completed, amount of time spent, name and qualifications of mentor</li> <li>Online training: Printed certificate, if available, or printed summary of training topic, sponsor organization, training content</li> </ul>

Professional conference	4 or more hours in length	Certificate will give # of hours, which will include time in conference sessions, not counting breaks or meals	<ul style="list-style-type: none"> <li>• Inservice training: Certificate, if available, or written summary of training topic, sponsor organization, training content</li> </ul> Certificate
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Frequently Asked Questions about What Counts as Training for Recertification:

1. Is it possible to use an observation as a training activity (i.e. someone wants to learn about how speech therapy works by observing a therapist)?  
In order to be considered as part of the 30 hours, the experience would need to be more structured than simply observing. For example, the activity might include preparation of the learner prior to the observation (reading materials, identification of what to be on the lookout for during the observation) and follow up discussion/mentoring after the observation.
2. How much flexibility do we have in using coordination with those who have expertise in a particular area – i.e. scheduling 1:1 to meet with a system manager about Part C updates?  
One-on-one training with individuals with the expertise the learner is seeking makes sense. However, discussion with system managers about Part C Updates would not meet the intent of the training requirements.
3. To what extent can meetings serve as trainings – particularly in the area of updating on Part C – i.e. council meetings, service coordination meetings?  
Meetings do not count toward the 30 hours of required training.
4. Does the Part C Leadership Academy count?  
Yes, if for the individual attending the training it addresses one of the 4 topic areas specified in 1b under “Requirements and Process for Recertification.”
5. When a service coordinator attends Kaleidoscope I and II, does that count towards her 30 hours?  
Yes
6. Does it count toward my 30 hours if I’m the one providing the training?  
Being the trainer does not give you hours toward recertification.

**TABLE A - PRACTITIONER QUALIFICATIONS AND RESPONSIBILITIES**

Discipline	Qualifications	Practitioner Level		Scope of Responsibilities						EI Services
		Professional	Specialist	Screening	Elig Det.	Assessment	Direct Child/Family	Teaming	Supervise Staff	
Audiologist	Licensure in Audiology by the Board of Audiology and Speech-Language Pathology	X		X	X	X	X	X	X	Audiology, Developmental Services
Certified Therapeutic Recreation Specialist	Certification through the National Council on Therapeutic Recreation Certification	X		X	X	X	X	X	X	Developmental Services, Assistive Technology Services
Counselor - including Licensed Professional Counselor	Licensure as Licensed Professional Counselor by the Virginia Board of Counseling	X		X	X	X	X	X	X	Counseling Services
School Counselor	Licensure with an endorsement as a School Counselor (pre K – 12) by the Virginia Board of Education	X		X	X	X	X	X	X	Counseling Services
Early Intervention Assistant	GED, High School Diploma or College Degree		X	X w/training			X w/Supervision	X		Developmental Services
Early Intervention Service Coordinator	GED, High School Diploma or College Degree	N/A	N/A	X w/training			X	X	X other SCs	Service Coordination
Educators -including Early Childhood Special Education	Licensure with an endorsement in Special Education - Early Childhood (birth-5) by the Virginia Board of Education	X		X	X	X	X	X	X	Developmental Services, Assistive Technology Services

Discipline	Qualifications	Practitioner Level		Scope of Responsibilities						EI Services
		Professional	Specialist	Screening	Elig Det.	Assessment	Direct Child/Family	Teaming	Supervise Staff	
Educators (cont.) Educator	Licensure with endorsement in Early/Primary Education (PreK – 3) or NK-4 or elementary education (PreK-6) by the Virginia Board of Education									Developmental Services, Assistive Technology Services
	Licensure with endorsement in Career and Technical Education-Family and Consumer Sciences by the Virginia Board of Education	X		X	X	X	X	X	X	
	Technical Professional License in Career and Technical Education-Family and Consumer Sciences by the Virginia Board of Education									
Educator of the Hearing Impaired	Licensure with endorsement in Special Education - Hearing Impairments (pre K – 12) by the Virginia Board of Education	X		X	X	X	X	X	X	Developmental Services, assistive Technology Services
Educator of the Visually Impaired	Licensure with endorsement in Special Education - Visual Impairments (pre K – 12) by the Virginia Board of Education	X		X	X	X	X	X	X	Developmental Services, Vision Services, Assistive Technology Services

Discipline	Qualifications	Practitioner Level		Scope of Responsibilities						EI Services
		Professional	Specialist	Screening	Elig Det.	Assessment	Direct Child/Family	Teaming	Supervise Staff	
Family and Consumer Science Professional	Employed in Virginia's Part C system before July 1, 2009: Certification through the American Association of Family and Consumer Sciences.  Employed on or after July 1, 2009: Certification with successful completion of the concentration examination in human development and family studies through the American Association of Family and Consumer Sciences.	X		X	X	X	X	X	X	Developmental Services, Assistive Technology Services
Family therapist	Licensure as Marriage and Family Therapist by the Virginia Board of Counseling	X		X	X	X	X	X	X	Counseling Services
Music Therapist	Certification by Certification Board for Music Therapy (MT-BC)	X		X	X	X	X	X	X	Developmental Services
Nurse - Includes Registered Nurse and Nurse Practitioner	Licensure by the Virginia Board of Nursing as a registered nurse or Licensure by the Virginia Board of Nursing as a nurse practitioner	X		X	X	X	X	X	X	Nursing Services, Developmental Services, Assistive Technology Services
Occupational Therapist	Licensure as Occupational Therapist by the Virginia Board of Medicine	X		X	X	X	X	X	X	Occupational Therapy, Assistive Technology Services
Occupational Therapy Assistant	Licensure as Occupational Therapy Assistant by the Virginia Board of Medicine		X	X w/training			X w/Supervision	X		Occupational Therapy, Assistive Technology Services

Discipline	Qualifications	Practitioner Level		Scope of Responsibilities						EI Services
		Professional	Specialist	Screening	Elig Det.	Assessment	Direct Child/Family	Teaming	Supervise Staff	
Orientation and Mobility Specialist	Certification by the National Blindness Professional Certification Board as a National Orientation and Mobility Certificant (NOMC); OR certification by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) as a Certified Orientation and Mobility Specialist (COMS)	X		X	X	X	X	X	X	Vision Services, Assistive Technology Services
Physical Therapist	Licensure as Physical Therapist by the Virginia Board of Physical Therapy	X		X	X	X	X	X	X	Physical Therapy, Assistive Technology Services
Physical Therapist Assistant	Licensure as Physical Therapist Assistant by the Virginia Board of Physical Therapy		X	X w/training			X w/Supervision	X		Physical Therapy, Assistive Technology Services
Physician	Licensure in Medicine or Osteopathic Medicine by the Virginia Board of Medicine	X		X	X	X	X	X	X	Medical Services
Psychologist – including Clinical psychologist	Licensure as Clinical Psychologist by Virginia Board of Psychology	X		X	X	X	X	X	X	Psychological services
School psychologist	Licensure with endorsement in School Psychology through the Virginia Board of Education	X		X	X	X	X	X	X	Psychological services
Applied psychologist	Licensure as Applied Psychologist by Virginia Board of Psychology	X		X	X	X	X	X	X	Psychological services



Discipline	Qualifications	Practitioner Level		Scope of Responsibilities						EI Services
		Professional	Specialist	Screening	Elig Det.	Assessment	Direct Child/Family	Teaming	Supervise Staff	
Registered Dietitian	Registration by the Commission on Dietetic Registration	X		X	X	X	X	X		Nutrition Services
Social Worker – including Licensed Social Worker	Licensure as Licensed Social Worker by the Virginia Board of Social Work		X	X w/training			X w/Supervision	X		Social Work Services
Licensed Clinical Social Worker	Licensure as Licensed Clinical Social Worker by the Virginia Board of Social Work	X		X	X	X	X	X	X	Social Work Services
School Social Worker	Licensure with endorsement as a school social worker by the Virginia Board of Education	X		X	X	X	X	X	X	Social Work Services
Speech-Language Pathologist	Licensure in Speech-Language Pathology by the Virginia Board of Audiology and Speech-Language Pathology	X		X	X	X	X	X	X	Speech-Language Pathology, Assistive Technology Services
Licensed Practical Nurse	Licensure as Practical Nurse by the Virginia Board of Nursing		X	X w/training			X w/Supervision	X		Nursing Services, Developmental Services
Certified Nurse Aide	Certification as Nurse Aide by the Virginia Board of Nursing		X	X w/training			X w/Supervision	X		Nursing Services, Developmental Services

## GLOSSARY

Activity setting – A situation specific experience, opportunity, or event that involves a child's interactions with people and the physical environment; the social and physical places where learning takes place (from Dunst and Bruder, Family and "Community Activity Settings, Natural Learning Environments, and Children's Learning Opportunities," Children's Learning Opportunities Report, 1999, vol. 1, number 2)

Assessment - Reviewing available pertinent records that relate to the child's current health status and medical history and conducting personal observation and other procedures in order to identify the child's unique strengths and needs, including an identification of the child's level of functioning in each of the following developmental areas: cognitive development; physical development, including vision and hearing; communication development; social or emotional development; and adaptive development based on objective criteria, which must include informed clinical opinion

Assistive technology device - Any item, piece of equipment or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of children with disabilities. The term does not include a medical device that is surgically implanted, including cochlear implants, or the optimization (e.g., mapping), maintenance or replacement of that device

Assistive technology services - Any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. Assistive technology services include:

- The assessment of the needs of a child with a disability, including a functional assessment of the child in the child's customary environment;
- Purchasing, leasing or otherwise providing for the acquisition of assistive technology devices by children with disabilities;
- Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices;
- Coordinating and using other therapies, interventions, supports or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
- Training or technical assistance for a child with disabilities, that child's family, other caregivers or service providers on the use of assistive technology determined to be appropriate; and
- Collaboration with the family and other early intervention service providers identified on an infant or toddler's IFSP.

Audiology –

- Identification of children with auditory impairment, using at risk criteria and appropriate audiological screening techniques;
- Determination of the range, nature, and degree of hearing loss and communication functions, by use of audiological assessment procedures;
- Referral for medical and other services necessary for the habilitation or rehabilitation of children with auditory impairment;
- Provision of services including auditory training, aural rehabilitation, sign language and cued language services, speech reading and listening device orientation and training, and other training to increase the functional communication skills of an infant or toddler with a significant hearing loss;

- Provision of services for the prevention of hearing loss;
- Determination of the child's need for individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices;
- Family training, education and support provided to assist the family of an infant or toddler with a significant hearing loss in understanding his or her functional developmental needs related to the hearing loss and to enhance his or her development; and
- Collaboration with the family, service coordinator and other early intervention service providers identified on an infant's or toddler's IFSP.

Charges – The rates established for each service. Charges form the basis for the anticipated payment for services. Charges are generally established as the unit cost of providing care.

Child find – A comprehensive and coordinated system to locate, identify, refer and determine eligibility for all infant and toddlers with disabilities in Virginia who are eligible for services under Part C.

Co-payments and Deductibles – The amount the family must pay as a cost share in order to use their insurance.

Consent – Means that

- The parent has been fully informed of all information relevant to the activity for which consent is sought, in the parent's native language or other mode of communication;
- The parent understands and agrees in writing to the carrying out of the activity for which consent is sought, and the consent describes that activity and lists the records (if any) that will be released and to whom; and
- The parent understands that the granting of consent is voluntary on the part of the parent and may be revoked at any time.

Contact log – Monthly summary documenting dates and amount of delivered services.

Contact note - The term used to describe how Part C service provision, including service coordination, is to be documented. The term “contact note” is intended to be interchangeable with other commonly used terms such as “progress note,” “case note,” or “service coordination note.”

Counseling Services –

- Assessment and treatment of mental, emotional, or behavioral disorders and associated distresses that interfere with mental health;
- Individual and/or family group counseling with the parent(s) and other family members;
- Collaborating with the family, service coordinator and other early intervention service providers identified on an infant's or toddler's IFSP;
- Family training, education and support provided to assist the family of an infant or toddler with a disability in understanding his or her needs related to development, behavior or social-emotional functioning and to enhance his or her development.

Delinquent Account – An account that is unpaid after 30 days. When amount due by the family has been established under the family cost share practices and the family does not pay after 30 days, the account is considered to be delinquent.

#### Developmental services –

- Screening, assessment and intervention services to address the functional developmental needs of an infant or toddler with a disability with an emphasis on a variety of developmental areas including, but not limited to, cognitive processes, communication, motor, behavior and social interaction;
- Collaboration with the family, service coordinator and other early intervention service providers identified on an infant's or toddler's IFSP;
- Consultation to design or adapt learning environments, activities and materials to enhance learning opportunities for an infant or toddler with a disability;
- Family training, education and support provided to assist the family of an infant or toddler with a disability in understanding his or her functional developmental needs and to enhance his or her development.

Discipline - A specific occupational category that may provide early intervention supports and services to eligible children under Part C of the Individuals with Disabilities Education Act and their families

#### Early intervention services – developmental supports and services that

- Are designed to meet the developmental needs of an infant or toddler with a disability and the needs of the family related to enhancing the child's development, as identified by the Individualized Family Service Plan team, in any one or more of the following areas:
  - Physical development;
  - Cognitive development;
  - Communication development;
  - Social or emotional development;
  - Adaptive development.
- Are selected in collaboration with the parents
- Include –
  - Assistive technology devices and assistive technology services;
  - Developmental services;
  - Counseling services;
  - Health services;
  - Medical services, only for diagnostic or assessment purposes;
  - Nursing services;
  - Nutrition services;
  - Occupational therapy;
  - Physical therapy;
  - Psychological services;
  - Service coordination services;
  - Social work services;
  - Speech-language pathology and audiology services, including sign language and cued language services;
  - Vision services; and
  - Transportation and related costs.
- Are provided –
  - Under public supervision;
  - By qualified practitioners;
  - In natural environments, including home and community based settings in which children without disabilities participate, to the maximum extent appropriate;
  - In conformity with an Individualized Family Service Plan (IFSP); and

- In accordance with the family cost share practices specified in [State regulations].

Eligibility determination - The process by which a multidisciplinary team reviews medical reports, developmental screening results, parent report, observation summaries, and assessment summaries, if available, to determine whether or not a child meets the Infant & Toddler Connection of Virginia eligibility criteria (children from birth to age three who have a 25 percent developmental delay in one or more areas of development, atypical development, or a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay)

Family - Defined according to each family's definition of itself

Family assessment - The ongoing procedures used by appropriate qualified practitioners throughout the period of a child's eligibility for early intervention supports and services to identify the family's resources, priorities and concerns relative to enhancing the development of the child

Family fees – amounts acceptable as payments by families that are based on the accrued charges and co-payments incurred as a result of the services a child and family receive each month. The family fee cannot exceed the monthly cap as determined by the family cost share fee scale.

Fee Appeal Process – The process used when it can be determined that families have a demonstrated financial hardship and the discounted fee from the sliding fee scale also represents a financial burden

Financial hardship – A personal economic condition that may prevent a family from obtaining full and necessary services. The parameters defining financial hardship must correspond to the family size and family taxable income found in the family cost share fee scale. Financial hardship may also be created by co-payment and deductible requirements.

Health services - Services necessary to enable a child to benefit from the other early intervention supports and services during the time that the child is receiving the other early intervention supports and services. The term includes:

- Consultation by health care professionals with family members or other service providers who are identified on an infant's or toddler's IFSP concerning the special health care needs of the infant or toddler that will impact or need to be addressed during the provision of other early intervention services;
- Collaboration with the family and other early intervention service providers identified on an infant's or toddler's IFSP;
- Family training, education and support provided to assist the family of an infant or toddler with a disability in understanding his or her special health care needs; and
- Provision of such services as clean intermittent catheterization, tracheostomy care, tube feeding, the changing of dressings or colostomy collection bags, and other health services when necessary in order for the infant or toddler to participate in other early intervention services

The term does not include:

- Services that are surgical in nature (such as cleft palate surgery, surgery for club foot, or the shunting of hydrocephalus); purely medical in nature (such as hospitalization for management of congenital heart ailments, or the prescribing of medicine or drugs for any purpose); or related to the implementation, optimization (e.g., mapping),

maintenance, or replacement of a medical device that is surgically implanted, including cochlear implants;

- Devices (such as heart monitors, respirators and oxygen, and gastrointestinal feeding tubes and pumps) necessary to control or treat a medical condition; or
- Medical-health services (such as immunizations and regular "well-baby" care) that are routinely recommended for all children

Income – Wages and salaries that are consistent with the Federal definition of taxable wages. Income to be considered for family cost share purposes is that of the mother, father, and/or legal guardian of the family as is consistent with parental liability in the Code of Virginia.

Individualized Family Service Plan (IFSP) - A written plan for providing early intervention supports and services to eligible children and families that:

- Is developed jointly by the family and appropriate qualified practitioners providing early intervention supports and services;
- Is based on the multidisciplinary assessment for service planning; and
- Includes results or outcomes and supports and services necessary to enhance the development of the child and the capacity of the family to meet the special needs of the child.

Infant & Toddler Online Tracking System (ITOTS) – The secure online data system for the Infant & Toddler Connection of Virginia

Informed clinical opinion - The outcome of using information gathered through eligibility determination and/or assessment for service planning methods combined with professional expertise and experience to determine the child's developmental status and eligibility under Part C.

Local lead agency - Entity that, under contract with the State Lead Agency, administers local Part C funds and fulfills the requirements of the *Contract for Continuing Participation in Part C Early Intervention for Infants and Toddlers with Disabilities and Their Families*

Medical services - Services provided by a licensed physician for diagnostic or eligibility determination purposes to determine a child's developmental status and need for early intervention supports and services

Monthly cap – The maximum amount, as determined by the family cost share fee scale or fee appeal process, that a family will be required to pay per month for early intervention services regardless of the charge(s) or number of different types, frequency or intensity of services a child and family receive.

Multidisciplinary - The involvement of two or more disciplines in the provision of integrated and coordinated supports and services, including eligibility determination and assessment for service planning activities and development of the IFSP

Native language - The language or mode of communication normally used by the parents of the child or, in all direct contact with a child (including assessment of the child), the language or mode of communication normally used by the child in the home or learning environment

Natural environment(s) - Settings that are natural or normal for the child's age peers who have no disability

Nursing services – Nursing support necessary to enable a child to benefit from the other early intervention supports and services during the time that the child is receiving the other early intervention supports and services. The term includes:

- The assessment of health status for the purpose of providing nursing care, including the identification of patterns of human response to actual or potential health problems;
- The provision of nursing care to prevent health problems, restore or improve functioning and promote optimal health and development; and
- The administration of medications, treatment, and regimens prescribed by a licensed physician.

Nutrition services –

- Assessment of the nutritional and feeding status of an infant or toddler with a disability related to his or her development;
- Collaboration with the family, service coordinator and other early intervention service providers identified on an infant's or toddler's IFSP;
- Development, implementation and monitoring of appropriate plans to address the nutritional needs of children eligible for early intervention supports and services, based on the findings of individual assessments;
- Referral to community resources to carry out nutritional goals and referrals for community services, health or other professional services, as appropriate; and
- Family training, education and support provided to assist the family of an infant or toddler with a disability in understanding his or her needs related to nutrition and feeding and to enhance his or her development

Occupational therapy - Services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include:

- Screening, assessment and intervention services to address the functional developmental needs of an infant or toddler with a disability with an emphasis on self-help skills, fine and gross motor development, mobility, sensory integration, behavior, play and oral-motor functioning
- Adaptation of the environment, and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills;
- Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability;
- Collaboration with the family, service coordinator and other early intervention service providers identified on an infant's or toddler's IFSP;
- Family training, education and support provided to assist the family of an infant or toddler with a disability in understanding his or her functional developmental needs and to enhance his or her development

OSEP child indicators – The measures of child progress on which states must annually report to the Office of Special Education Programs (OSEP). The indicators are the percentage of infants and toddlers with IFSPs who demonstrate improved:

- Positive social-emotional skills (including positive social relationships)
- Acquisition and use of knowledge and skills (including early language/communication); and
- Use of appropriate behaviors to meet their needs.

Parent –

- A biological or adoptive parent of a child;
- A foster parent, unless contractual obligations with a State or local entity prohibit a foster parent from acting as a parent;
- A guardian generally authorized to act as the child's parent, or authorized to make early intervention, educational, health or developmental decisions for the child (but not the State if the child is a ward of the State);
- An individual acting in the place of a biological or adoptive parent (including a grandparent, stepparent or other relative) with whom the child lives, or an individual who is legally responsible for the child's welfare); or
- A surrogate parent.

If a judicial decree or order identifies a specific person or persons listed above to act as the "parent" of a child or to make health, educational or early intervention decisions on behalf of a child, then such person or persons shall be determined to be the "parent" for Part C purposes. Otherwise, the biological or adoptive parent, when attempting to act as the parent and when more than one party is qualified under the definition of "parent," must be presumed to be the parent unless the biological or adoptive parent does not have legal authority to make educational decisions for the child. The term "parent" does not include any local or state agency, or their agents, including the Department of Social Services and their local departments, if the child is in the custody of said agency.

Part B – The part of the Individuals with Disabilities Education Act that governs special education and related services for children and youth with disabilities

Part C – The part of the Individuals with Disabilities Education Act that governs early intervention services for infants and toddlers with disabilities and their families

Personally identifiable information –

- The name of the child, the child's parent, or other family member;
- The address of the child;
- A personal identifier, such as the child's or parent's social security number; or
- A list of personal characteristics or other information that would make the child's or parent's identity easily traceable

Physical therapy - services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. These services include:

- Screening, assessment and intervention services to address the functional developmental needs of an infant or toddler with a disability with an emphasis on mobility, positioning, fine and gross motor development, balance, flexibility, and both strength and endurance, including the identification of specific motor disorders;
- Adaptation of the environment, and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills;
- Collaboration with the family, service coordinator and other early intervention service providers identified on an infant's or toddler's IFSP; and
- Family training, education and support provided to assist the family of an infant or toddler with a disability in understanding his or her functional developmental needs and to enhance his or her development.

Practitioner - An individual who is qualified to provide supports and services



Provider (Service provider) – A practitioner selected to deliver early intervention supports and services

Psychological services –

- Administration of psychological and developmental tests, and other assessment procedures;
- Interpretation of assessment results;
- Obtaining, integrating, and interpreting information about child behavior, and child and family conditions related to learning, mental health, and development;
- Planning and management of a program of psychological services, including psychological counseling for children and parent(s), family counseling, consultation on child development, parent training, and education programs;
- Collaboration with the family, service coordinator and other early intervention service providers identified on an infant's or toddler's IFSP;
- Family training, education and support provided to assist the family of an infant or toddler with a disability in understanding his or her needs related to development, cognition, behavior or social-emotional functioning and to enhance his or her development

Screening - Procedures used to identify infants and toddlers suspected of having a disability and to be in need of early intervention services, at the earliest possible age

Service coordination - The activities carried out by a service coordinator to assist and enable a child eligible for early intervention supports and services and the child's family to receive the rights, procedural safeguards, and supports and services that are authorized to be provided under Virginia's early intervention program

Single point of entry - The single entity in each local Part C system where families and primary referral sources make initial contact with the local Part C system

Sliding fee scale – A matrix utilizing taxable family income in conjunction with family size to determine the monthly cap to be paid that is less than the full charge. In the Infant & Toddler Connection of Virginia, the sliding fee scale is referred to as the family cost share fee scale.

Social work services -

- Home visits to evaluate a child's living conditions and patterns of parent-child interaction;
- Social or emotional developmental screening and assessment of the child within the family context;
- Individual and family-group counseling with parent(s) and other family members, and appropriate social skill-building activities with the child and parent(s);
- Intervention to address those problems in a child's and family's living situation (home, community, and any other location where early intervention supports and services are provided) that affect the child's maximum utilization of early intervention supports and services;
- Identification, mobilization, and coordination of community resources and services to enable the child and family to receive maximum benefit from early intervention supports and services;
- Collaboration with the family, service coordinator and other early intervention service providers identified on an infant's or toddler's IFSP; and

- Family training, education and support provided to assist the family of an infant or toddler with a disability in understanding his or her functional developmental needs and to enhance his or her development.

Speech-language pathology –

- Screening, assessment and intervention services to address the functional, developmental needs of an infant or toddler with a disability with an emphasis on communication skills, language and speech development, sign language and cued language services and oral motor functioning, including the identification of specific communication disorders
- Referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communicative or oropharyngeal disorders and delays in development of communication skills
- Collaboration with the family, service coordinator and other early intervention service providers identified on an infant's or toddler's IFSP; and
- Family training, education and support provided to assist the family of an infant or toddler with a disability in understanding his or her functional development needs and to enhance his or her development.

Surrogate parent - A person appointed to provide children who are wards of the state, whose parent(s) cannot be identified and/or whose whereabouts are unknown, with the protection of their rights

Transition - The entry or exit of children and families to and from early intervention supports and services

Transportation and related costs - Include the cost of travel (e.g., mileage, or travel by taxi, common carrier, or other means) and other costs (e.g., tolls and parking expenses) that are necessary to enable a child eligible for early intervention supports and services and the child's family to receive early intervention supports and services

Vision services –

- Assessment and intervention services to address the functional developmental needs of an infant or toddler with a significant vision impairment with an emphasis on sensory development, communication skills development, orientation and mobility skill development and adaptive skills training;
- Consultation to adapt the environment to promote development, access and participation of an infant or toddler with a significant vision impairment;
- Referral for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorders, or both
- Collaboration with the family, service coordinator and other early intervention service providers identified on an infant's or toddler's IFSP; and
- Family training, education and support provided to assist the family of an infant or toddler with a disability in understanding his or her functional development needs related to the vision impairment and to enhance his or her development

Visit – A face-to-face encounter with the child and/or family for the purpose of providing early intervention supports and services.

Ward of the state – A child who, as determined by Virginia, is a foster child or is in the custody of a public child welfare agency. The term does not include a foster child who has a foster parent who meets the definition of “parent.”